ANALYSIS

This ordinance amends Title 5 – Personnel of the Los Angeles County Code relating to Fringe Benefits by:

- Amending portions of Sections 5.27.040, 5.27.240, 5.28.040 and 5.28.240 relating to cafeteria plan contributions for non-represented employees;
- Amending portions of Sections 5.27.220, 5.27.450, 5.28.220, 5.28.450, relating to long term disability health insurance coverage for non-represented employees enrolled in the Megaflex Plan;
- Amending Section 5.37.020, deleting and restating Chapters 5.29 and 5.34 and adding new Chapter 5.41 relating to dependent care reimbursement for County employees;
- Amending Section 5.33.040 relating to cafeteria plan contributions for certain represented employees;
- Amending Section 5.36.080 relating to County dental insurance contributions for certain represented employees;
- Deleting and restating Section 5.38.010 and amending a portion of Section 5.38.020 relating to long term disability health insurance for represented employees and non-represented employees enrolled in the Flex Plan; and
- Amending 5.39.030 relating to supplemental life insurance for designated employees.

RAYMOND G. FORTNER, JR.
County Counsel

By: _____
HALVOR S. MELOM
Principal Deputy County Counsel
Labor & Employment Division

HSM:asv
Requested: 12-18-07
Revised: 02-27-08

ORDINANCE NO. _____

An ordinance amending Title 5 - Personnel of the Los Angeles County Code, relating to fringe benefits and leaving vacation.

The Board of Supervisors of the County of Los Angeles ordains as follows:

SECTION 1. Section 5.27.040 is hereby amended to read as follows:

5.27.040 Contributions.

A. Nonelective Contributions. Except as otherwise provided herein, each month the County shall contribute to the Plan on behalf of each Participant an amount equal to the greater of ~~$678.00~~$735.00 or 10 percent of such Participant's Compensation for the preceding month beginning the ~~2007~~2008 Plan Year; provided, however, that no Nonelective Contribution shall be contributed for any Participant if he has not been in a pay status for at least eight hours during the prior month. Nonelective Contributions shall be reflected in County payroll warrants issued on or about the fifteenth day of the month following the month in which the requisite pay status was completed.

...

SECTION 2. Section 5.27.220 is hereby amended to read as follows:

5.27.220 Definitions.

The following terms, when used herein with initial capital letters, unless the context clearly indicates otherwise, shall have the following respective meanings:

A. "Applicable Health Insurance Coverage" means coverage under a County-sponsored medical plan offered through the Plan for which an employee, Medical Dependent or LTD Health Survivor would be eligible if the employee were not disabled or deceased.

~~A.~~ B. "Basic Monthly Compensation" means the average Compensation for the position or positions the Eligible Participant held during the 12 consecutive months immediately preceding the Waiting Period.

~~B.~~ C. "Benefit" means cash and/or one or more Nontaxable Benefits or Taxable Benefits.

~~C.~~ D. "Board" means the Los Angeles County Board of Supervisors.

~~D.~~ E. "~~CAO~~ CEO" means the Chief ~~Administrative~~ Executive Officer of the County appointed by the Board pursuant to the Los Angeles County Code.

~~E.~~ F. "Claims Administrator" means the County department, contracted insurance company, or contracted service company designated by the ~~CAO~~ CEO to be responsible for the adjudication and processing of claims filed under the Short-Term Disability and Long-Term Disability Plans.

~~F.~~ G. "Code" means the Internal Revenue Code of 1986, as amended.

~~G.~~ H. "Compensation" means the monthly base rate, as established in Title 6 of the Los Angeles County Code, as amended, plus any monthly bonus established as a designated number of schedules and/or levels in the Standardized Salary Schedule

contained in such Title 6 or established as a percentage of the base rate pursuant to Part 3 of Chapter 6.08, Management Appraisal and Performance Plan, of Title 6, Compensation, shall not include any of the following:

1. Overtime compensation;

2. Any lump-sum payoff or reimbursement for unused, accumulated overtime, vacation, holiday time, sick leave, or annual leave benefits;

3. Compensation pursuant to Section 6.16.010 of the Los Angeles County Code;

4. Any hourly bonus;

5. Any monthly bonus established as a flat dollar amount or as a percentage of the base rate except that Compensation shall include any monthly bonus paid as a percentage of the base rate for employees compensated pursuant to Part 3 of Chapter 6.08 entitled Management Appraisal and Performance Plan of the Los Angeles County Code.

~~H.~~ I. "Contribution" means any Nonelective Contribution or Elective Contribution made on behalf of a Participant pursuant to Section 5.27.240.

~~I.~~ J. "County" means the County of Los Angeles and (1) any governmental entity of which the Board is the governing body; and (2) the County Municipal Courts and the Los Angeles County Superior Court to the extent the operation of this Plan in said courts is otherwise authorized by state law or rules of court.

K. "Covered Employee" means an employee who is an Eligible Employee or a Participant and enrolled in a County-sponsored medical plan.

~~J.~~ L. "Disability" or "Disabled" means, during the Waiting Period and the subsequent period for which a Participant might be eligible to receive benefits under the Short-Term Disability Plan, the continuous inability and incapacity of the Eligible Participant to perform the regular and customary duties of his position with the County at the time and place designated by the County.

~~K.~~ M. "Domestic Partner" means a qualified person pursuant to the provisions of Chapter 2.210 of the Los Angeles County Code or Section 298.5, California Family Code, as applicable.

~~L.~~ N. "Election Information" means the information and rules relating to the general administration of the Plan. The ~~CAO~~ CEO shall develop and issue such information and rules, except as otherwise provided by the Board. Such information shall include, but not be limited to the following:

1. The cost to be charged to Participants for elective coverage, including the manner and timing of payment;

2. Rules relating to election procedures and deadlines, including rules relating to the disposition of benefits for Eligible Employees who fail to meet election deadlines;

3. Rules relating to the disposition of benefits for Participants who enter or exit the Plan during a Plan Year, or who experience an interruption of active service;

4. Rules relating to the administration of the various benefits contained within the Plan, including rules relating to the year-to-year availability of such

benefits. Such rules may place restrictions on Participant access to nonelective or elective coverage if such restrictions are necessary to protect the financial well-being of the Plan, to comply with restrictions imposed by insurance carriers, or to preserve the status of the Plan as a cafeteria plan within the meaning of Section 125 of the Code.

~~M.~~ O. "Elective Contribution" means the amount allocated to specific Taxable Benefits and/or Nontaxable Benefits at the election of a Participant equal to a reduction in his Eligible Earnings pursuant to Section 5.27.240 B.

~~N.~~ P. "Eligible Earnings" means any compensation paid to an Eligible Employee for service performed for the County which is currently includible in gross income under the Code.

~~O.~~ Q. "Eligible Employee" means a full-time permanent employee of the County who is not in an Excluded Bargaining Unit and who is designated by the Board as eligible to participate in the Plan. For purposes hereof, "full-time permanent" means any employee appointed to an "A," "L" or "N" item pursuant to Title 6 of the Los Angeles County Code. "Eligible Employee" shall also mean any employee appointed to "D" item pursuant to said Title 6 who is required to possess a California license to practice as a Registered Nurse or an employee of the County appointed to a monthly temporary training "M" item pursuant to Title 6 of the Los Angeles County Code who is not in an Excluded Bargaining Unit and who is designated by the Board as eligible to participate in the Plan. However, the County and representatives of an Excluded Bargaining Unit may, subject to approval by the Los Angeles County Board of Supervisors, agree that any employee who would otherwise cease to be an Eligible Employee because of

certification or accretion of the employee' s employment classification into an Excluded Bargaining Unit may continue as an Eligible Employee for such period as may be established in such agreement.

~~P.~~ R. "Eligible Participant" means a Participant who becomes disabled as a direct consequence and result of injury or disease.

~~Q.~~ S. "Evidence of Disability" means a statement of medical certification of disability submitted by a Physician to the Claims Administrator.

~~R.~~ T. "Excluded Bargaining Unit" means an employee representation unit, unless the representative of such unit and the County agree that the employees in such unit shall be covered hereunder.

U. "LTD Health Insurance Benefit" means a benefit that pays for 75 percent or 100 percent of the cost of Applicable Health Insurance Coverage at the time such coverage is provided pursuant to the rules in section 5.27.450.

V. "LTD Health Survivor" means a spouse, domestic partner as defined in Section 298.5 of the California Family Code, or dependent child (including a stepchild or adopted child) who is under age 19 or who is a full-time student under age 25, of (1) an Eligible Participant who dies while receiving or entitled to receive disability benefits under section 5.27.460; or (2) a Covered Employee who dies as a direct consequence and result of injury or disease; provided, however, that to be an LTD Health Survivor, an individual must be a spouse, domestic partner or dependent child who is covered by a County-sponsored medical plan offered under the Cafeteria Plan at the time of: (i) the onset of a total disability as determined by the Claims Administrator, or (ii) if the

Covered Employee dies before he makes a claim for disability under the LTD Plan, the date of death.

~~S.~~ W. "Materials" means the booklets, manuals, handbooks, contracts, plan documents or sections thereof and other provisions of the Los Angeles County Code relating to the County-sponsored or County-approved employee benefit plans approved for inclusion in Subdivision 2 of the Plan by the Board.

X. "Medical Dependent" means a Covered Employee's spouse, domestic partner or dependent child who is eligible to be covered under the terms of a County-sponsored medical plan.

~~T.~~ Y. "Nonelective Contribution" means the amount available for allocation to particular Taxable Benefits and/or Nontaxable Benefits or for receipt as additional Eligible Earnings by a Participant pursuant to Section 5.27.240 A.

~~U.~~ Z. "Nonindustrial" means an injury or disease that the chief ~~administrative~~ executive officer or the workers' compensation appeals board has not yet determined to be compensable under the workers' compensation laws of the state of California or an injury or disease which has been determined not to be so compensable.

~~V.~~ AA. "Nontaxable Benefit" means participation in any employee benefit program provided or sponsored by the County, insured or uninsured, now existing or hereafter adopted, for inclusion in the plan the cost of which is excludible from the gross income of the Participant pursuant to Sections 79, 105, 106, or 129 of the Code or any other applicable Code section, as the same may be amended.

~~W.~~BB. "Participant" means any Eligible Employee or former Employee who meets the requirements for participation in the Plan set forth in Section 5.27.230.

~~X.~~CC. "Physician" means any physician, surgeon, osteopath, psychiatrist, psychologist, chiropractor or other medical practitioner who is duly licensed by the state in which he practices and who is practicing within the scope of his license.

~~Y.~~DD. "Plan" means the County of Los Angeles Flexible Benefit Plan, as set forth in this Subdivision 2, as the same may be amended or restated from time to time.

~~Z.~~EE. "Plan Year" means the calendar year.

~~AA.~~FF. "Retirement Plan A, B, C, or D Member" means an Eligible Employee or a Participant who is covered by any of the contributory retirement plans established for general or safety members of the Los Angeles County Employees Retirement Association pursuant to the County Employees Retirement Law of 1937. For the sole purpose of determining entitlement to Nonelective Contributions and Nontaxable Benefits and Taxable Benefits provided under the Plan, an Eligible Employee or Participant employed on a monthly temporary training "M" item basis pursuant to Title 6 of the Los Angeles County Code shall be treated as if he were a Retirement Plan A, B, C, or D Member. In no event shall such Eligible Employee or Participant be entitled to any benefit under the County Employees Retirement Law of 1937 by reason of this treatment.

~~BB.~~GG. "Retirement Plan E Member" means an Eligible Employee or a Participant who is covered by the optional noncontributory retirement plan made

operative for general members of the Los Angeles County Employees Retirement Association on or after July 1, 1981.

~~GG.~~HH."SIB Compensation" means an SIB Participant's Compensation in the month preceding his death, or the commencement of benefits under the LTD Plan, whichever occurs first.

~~DD.~~II. "SIB Participant" means a Retirement Plan E Member who is:

1. A Participant who has elected coverage under the SIB Plan for the current Plan Year; or

2. A former Participant who is disabled and receiving benefits under the LTD Plan, and who elected coverage under the SIB Plan for the Plan Year in which his LTD benefits commenced.

~~EE.~~JJ."Taxable Benefit" means participation in certain health or welfare programs provided or sponsored by the County, insured or uninsured, now existing or hereafter adopted, described in the Materials, the cost of which will be treated by the County as includible in the gross income of the Participant pursuant to the Code as the same may be amended.

~~FF.~~KK."Total Disability" or "Totally Disabled" means during the Waiting Period and during the subsequent 24-month period for which a Participant might be eligible to receive benefits under the LTD Plan, the complete and continuous inability and incapacity of the Participant to perform the duties of his position with the County. After the expiration of 24 consecutive months of eligibility for benefit payments, "Total Disability" or "Totally Disabled" means the Participant is Disabled within the meaning of

the Federal Social Security Act and is eligible to receive or is receiving disability benefits under the Federal Social Security Act; provided, however, that for a participant who makes timely application for disability benefits under the Federal Social Security Act and who has not received a final determination regarding disability under the Act, "Total Disability" or "Totally Disabled" (for the period prior to the date on which a final determination is made regarding disability) shall mean the complete and continuous inability and incapacity of the Participant to perform the duties of his position with the County. A Participant who is not insured for disability benefits under the Federal Social Security Act (such as lacking sufficient quarters of covered employment) shall be considered Totally Disabled at the end of the 24-month period of eligibility for benefit payments and during the continuance thereafter of the disability if he is disabled within the meaning of Section 223(d) of the Federal Social Security Act.

~~GG.~~LL.1. "Waiting Period" for purposes of the Short-Term Disability Plan means that a waiting period shall be required with respect to any one Disability, and that such period shall be a continuous period equal to 14 days, except as reduced by elective option. The Waiting Period shall commence with the first day the Participant is Disabled, and shall continue during the time he remains Disabled.

2. "Waiting Period" for purposes of the Long-Term Disability Plan means that a waiting period shall be required with respect to any one Total Disability, and shall be a continuous period equal to six months, commencing with the first day on which an eligible employee is absent from work due to a total disability, and during which he or she remains totally disabled except as provided below. If the eligible

employee ceases to be totally disabled and returns to work for less than an aggregate of 30 days during a waiting period, any such cessation of total disability shall not interrupt continuity or extend the duration of the waiting period used to determine the first day on which benefits commence, provided that the successive absences during the waiting period are due to the same cause. The waiting period shall not include any time prior to January 1, 1991.

3. The continuity of the Waiting Period shall not be interrupted, nor shall the Waiting Period be extended, merely because an Eligible Participant incurs a disability during such period that arises from a different and unrelated cause than that which initially caused the Eligible Participant to be absent from work.

4. The Election Information may establish rules under which an Eligible Participant may return to work on a trial basis during the Waiting Period without causing any interruption or extension of said period.

SECTION 3. Section 5.27.240 is hereby amended to read as follows:

5.27.240 Contributions.

A. Nonelective Contributions.

1. Except as otherwise provided herein, each month the County shall contribute to the Plan on behalf of each Participant an amount equal to the greater of ~~$918.00~~ $987.00 beginning the ~~2007~~ 2008 Plan Year or the amount designated in subsection A1a or b below, whichever is applicable:

...

SECTION 4. Section 5.27.450 is hereby amended to read as follows:

5.27.450 Election and benefit costs.

A. Nonelective Coverage. Each Retirement Plan E Member who has completed five or more years of continuous service as of the commencement of the current Plan Year, shall be entitled to nonelective LTD coverage equal to his Basic Monthly Compensation multiplied by 40 percent.

B. Elective Coverage.

1. Each Retirement Plan A, B, C, or D Member may elect LTD coverage equal to his Basic Monthly Compensation multiplied by 40 percent, or 60 percent.

2. Each Retirement Plan E Member who has less than five years of continuous service as of the commencement of the Plan Year for which he is eligible to make an election, may elect LTD coverage equal to his Basic Monthly Compensation multiplied by 40 percent, or 60 percent.

3. Each retirement Plan E Member who has five or more years of continuous service as of the commencement of the Plan Year for which he is eligible to make an election, may elect LTD coverage equal to his Basic Monthly Compensation multiplied by 60 percent.

~~4. LTD Health Insurance.~~

~~a. Each Eligible Employee or Participant may elect a disability health insurance benefit hereinafter referred to as "LTD Health Insurance." LTD Health Insurance shall provide health insurance coverage on a concurrent basis with the~~

~~payment of benefits under Section 5.27.460. For each Eligible Employee or Participant who elects this option, LTD Health Insurance shall provide the employee with the health insurance coverage to which the Eligible Employee or Participant would otherwise be entitled as an active employee pursuant to the rules set forth in the Election Information and shall provide a subsidy toward the payment of that coverage equal to 75 percent of the total premium cost at the time the coverage is provided. The Eligible Employees and Participants receiving this subsidy shall pay the remaining 25 percent of the premium cost. Beginning on January 1, 2005, LTD Health Insurance will be extended to the survivor of an employee who is participating in the LTD Health Insurance protection program. A "survivor," for this purpose, shall mean a spouse, domestic partner as defined in Section 298.5 of the California Family Code, or dependent child as defined in the Election Information; provided, however, that no person shall receive LTD Health Insurance survivor benefits under this provision if he or she was not an eligible survivor as of the onset of disability as determined by the Claims Administrator or date of death where death occurs with no preceding claim for disability benefits by the Eligible Employee or Participant under the LTD Plan.~~

~~b. For new disabilities beginning on or after January 1, 2007, the LTD Health Insurance Benefits set forth in paragraph (a) above shall be applicable on a nonelective basis for all Participants otherwise eligible for LTD benefits. In addition, Eligible Employees and Participants may elect a 100 percent LTD Health Insurance benefit which shall provide a subsidy toward the payment of the health insurance coverage to which the Participant would otherwise be entitled as an active~~

~~employee equal to 100 percent of the total premium cost at the time the coverage is provided. The Eligible Employees and Participants electing this subsidy shall pay nothing toward the premium cost at the time the health insurance is actually received. Other rules regarding LTD Health Insurance benefit eligibility shall include the following:~~

~~1. For the 2007 Plan Year and for each Plan Year thereafter, any Eligible Employee or Participant who does not elect the optional 100 percent LTD Health Insurance benefit shall be ineligible to make such election for the following Plan Year. The Eligible Employee or Participant must wait two Plan Years before again being eligible to elect this option.~~

~~2. In the event a Participant retires and becomes eligible to receive retiree health insurance from LACERA, LTD Health Insurance benefits will cease.~~

~~3. An Eligible Employee or Participant who elects to buy the 100 percent LTD Health Insurance benefit while receiving LTD benefits or while in the Waiting Period shall be limited to the 75 percent nonelective LTD Health Insurance benefit and shall not be eligible to receive the 100 percent elective LTD Health Insurance benefit with respect to that same disability until the employee returns to active employment for six months or more.~~

~~4. Such other benefit eligibility rules as may be determined necessary by the Chief Administrative Officer and set forth in the Election Information for the prudent administration of the LTD Health Insurance program.~~

4. LTD Health Insurance Benefit.

a. Benefits for Eligible Employees.

(1) For disabilities incurred prior to January 1, 2007, if the Covered Employee timely elects and pays for the 75 percent LTD Health Insurance Benefit in accordance with the terms of the Plan, the Covered Employee is covered by an LTD Health Insurance Benefit that pays for 75 percent of the cost of Applicable Health Insurance Coverage for the employee and his Medical Dependents during the period described in section 5.27.450B.4.c. The Covered Employee must make monthly contributions to purchase the 75 percent LTD Health Insurance Benefit, in amounts determined by the County, in accordance with the terms of the Plan. The remaining 25 percent of the cost of Applicable Health Insurance Coverage elected by the employee shall be paid for by monthly employee payments in the time and manner determined by the County when the medical insurance coverage is received. Applicable Health Insurance Coverage will not be provided unless the employee timely remits his or her share of the cost for such coverage.

(2) For disabilities incurred on or after January 1, 2007, unless a Covered Employee makes the election provided in section 5.27.450B.4.a.(3), he is automatically covered, at no cost, by an LTD Health Insurance Benefit that pays for 75 percent of the cost of Applicable Health Insurance Coverage for the employee and his Medical Dependents during the period described in section 5.27.450B.4.c. The remaining 25 percent of the cost of any Applicable Health Insurance Coverage elected

by the employee shall be paid for by monthly employee payments in the time and manner determined by the County when the medical insurance coverage is received. Applicable Health Insurance Coverage will not be provided unless the employee timely remits his or her share of the cost for such coverage.

(3) Beginning January 1, 2007, for disabilities incurred after that date, if the Covered Employee timely elects and pays for the 100 percent LTD Health Insurance Benefit in accordance with the terms of the Plan, the Covered Employee is covered by an LTD Health Insurance Benefit that will pay for 100 percent of the cost of Applicable Health Insurance Coverage for the employee and his Medical Dependents during the period described in section 5.27.450B.4.c. The Covered Employee must make monthly contributions to purchase the 100 percent LTD Health Insurance Benefit, in amounts determined by the County, in accordance with the terms of the Plan.

b. Benefits for LTD Health Survivors

(1) Each LTD Health Survivor with respect to a Covered Employee described in section 5.27.450.B.4.a.(1) or (2) shall receive an LTD Health Insurance Benefit that pays for 75 percent of the cost of Applicable Health Insurance Coverage for that LTD Health Survivor during the period described in section 5.27.450B.4.c. The remaining 25 percent of the cost of any Applicable Health Insurance Coverage provided to the LTD Health Survivor shall be paid for by monthly payments by that individual in the time and manner determined by the County when the

medical insurance coverage is received. Applicable Health Insurance Coverage will not be provided unless the covered individual timely remits his or her share of the cost for such coverage.

(2) Each LTD Health Survivor with respect to an Eligible Employee or Participant who elects and purchases the 100 percent LTD Health Insurance Benefit as described in section 5.27.450.B.4.a.(3) shall receive an LTD Health Insurance Benefit that pays for 100 percent of the cost of Applicable Health Insurance Coverage for that LTD Health Survivor during the period described in section 5.27.450B.4.c.

c. Duration of the LTD Health Insurance Benefit. The LTD Health Insurance Benefit shall be provided: (1) in the case of benefits provided under Section 5.27.450B.4.a., during the period that total disability benefits are paid under Section 5.27.460; and (2) in the case of benefits provided under Section 5.27.450B.4.b., until the LTD Health Survivor's death or until the individual no longer qualifies as an LTD Health Survivor; provided, however, that, in the event an individual receiving LTD Health Insurance Benefits becomes eligible to receive any retiree health insurance coverage from the Los Angeles County Employees Retirement Association (whether or not he or she elects to receive that insurance coverage), that individual's LTD Health Insurance Benefits will cease.

d. Limitations. Notwithstanding any other provision governing the LTD Health Insurance Benefit:

(1) To be eligible to receive an LTD Health Insurance Benefit, a Covered Employee, Medical Dependent or LTD Health Survivor must be covered under a County-sponsored medical plan offered through the Cafeteria Plan at the time the LTD Health Insurance Benefit commences; provided, however, that an employee receiving an LTD Health Insurance Benefit may elect to cover a Medical Dependent during open enrollment in accordance with Plan rules or to the extent otherwise required by applicable law.

(2) Any eligible employee receiving disability benefits under this Chapter 5.27 or completing the Waiting Period: (1) shall not be entitled to become covered by (if not already covered), or elect to increase the level of, the LTD Health Insurance Benefit unless and until the employee returns to work as a Covered Employee, and (2) will not be entitled to become covered by (if not already covered), or elect to increase the level of, the LTD Health Insurance Benefit with regard to that same disability unless and until the employee returns to active employment as a Covered Employee for at least 6 months. Additionally, any Covered Employee who does not elect the optional 100 percent LTD Health Insurance Benefit shall be ineligible to make such election for the following Plan Year. The Covered Employee must wait two Plan Years before again being eligible to elect this option.

e. Additional benefit eligibility rules may be determined as necessary by the Chief Executive Officer for the prudent administration of the LTD

Health Insurance Benefit program and set forth in the applicable Cafeteria Plan documents and materials.

C. Cost. Nonelective LTD coverage shall be provided at no cost to the affected Participants. Elective LTD coverage, including elective LTD Health Insurance, shall require contributions from the affected Participants as provided for in the Election Information.

SECTION 5. Section 5.28.040 is hereby amended to read as follows:

5.28.040 Contributions.

A. Nonelective Contributions. Except as otherwise provided herein, each month the County shall contribute to the Plan on behalf of each Participant an amount equal to the greater of ~~$678.00~~ $735.00 or 10 percent of such Participant' s Compensation for the preceding month beginning the ~~2007~~ 2008 Plan Year; provided, however, that no Nonelective Contribution shall be contributed for any Participant if he has not been in a pay status for at least eight hours during the prior month. Nonelective Contributions shall be reflected in County payroll warrants issued on or about the fifteenth day of the month following the month in which the requisite pay status was completed.

...

SECTION 6. Section 5.28.220 is hereby amended to read as follows:

5.28.220 Definitions.

The following terms, when used herein with initial capital letters, unless the context clearly indicates otherwise, shall have the following respective meanings:

A. "Applicable Health Insurance Coverage" means coverage under a County-sponsored medical plan offered through the Plan for which an employee, Medical Dependent or LTD Health Survivor would be eligible if the employee were not disabled or deceased.

~~A.~~ B. "Basic Monthly Compensation" means the average monthly base rate, as established in Title 6 of this Code, as amended, on salaries, hereinafter referred to as "Title 6," for the position or positions the employee held during the 12 consecutive months immediately preceding the qualifying period; provided, however, that in no event shall the basic monthly compensation include the following:

1. Overtime compensation; or

2. Any lump sum payoff or reimbursement for unused accumulated overtime, vacation, holiday time, or sick leave benefits; or

3. Compensation from two or more positions held on a concurrent basis.

~~B.~~ C. "Benefit" means cash and/or one or more Nontaxable Benefits or Taxable Benefits.

~~C.~~ D. "Board" means the Los Angeles County Board of Supervisors.

~~D.~~ E. "~~CAO~~ CEO" means the Chief ~~Administrative~~ Executive Officer of the County appointed by the Board pursuant to the Los Angeles County Code.

~~E.~~ F. "Claims Administrator" means the County department, contracted insurance company, or contracted service company designated by the ~~CAO~~ CEO to be responsible for the adjudication and processing of claims filed under the Short-Term Disability and Long-Term Disability Plans.

~~F.~~ G. "Code" means the Internal Revenue Code of 1986, as amended.

~~G.~~ H. "Compensation" means the monthly base rate, as established in Title 6 of the Los Angeles County Code, as amended, plus any monthly bonus established as a designated number of schedules and/or levels in the Standardized Salary Schedule contained in such Title 6 or established as a percentage of the base rate pursuant to Part 3 of Chapter 6.08, Management Appraisal and Performance Plan, of Title 6, Compensation, shall not include any of the following:

1. Overtime compensation;

2. Any lump-sum payoff or reimbursement for unused, accumulated overtime, vacation, holiday time, sick leave, or annual leave benefits;

3. Compensation pursuant to Section 6.16.010 of the Los Angeles County Code;

4. Any hourly bonus;

5. Any monthly bonus established as a flat dollar amount or as a percentage of the base rate except that Compensation shall include any monthly bonus paid as a percentage of the base rate for employees compensated pursuant to Part 3 of

Chapter 6.08 entitled Management Appraisal and Performance Plan of the Los Angeles County Code.

~~H.~~ I. "Contribution" means any Nonelective Contribution or Elective Contribution made on behalf of a Participant pursuant to Section 5.28.240.

~~I.~~ J. "County" means the County of Los Angeles and (1) any governmental entity of which the Board is the governing body; and (2) the County Municipal Courts and the Los Angeles County Superior Court to the extent the operation of this Plan in said courts is otherwise authorized by state law or rules of court.

K. "Covered Employee" means an employee who is an Eligible Employee or a Participant and enrolled in a County-sponsored medical plan.

~~J.~~ L. "Disability" or "Disabled" means, during the Waiting Period and the subsequent period for which a Participant might be eligible to receive benefits under the Short-Term Disability Plan, the continuous inability and incapacity of the Eligible Participant to perform the regular and customary duties of his position with the County at the time and place designated by the County.

~~K.~~ M. "Domestic Partner" means a qualified person pursuant to the provisions of Chapter 2.210 of the Los Angeles County Code or Section 298.5, California Family Code, as applicable.

~~L.~~ N. "Election Information" means the information and rules relating to the general administration of the Plan. The ~~CAO~~ CEO shall develop and issue such information and rules, except as otherwise provided by the Board. Such information shall include, but not be limited to the following:

1. The cost to be charged to Participants for elective coverage, including the manner and timing of payment;

2. Rules relating to election procedures and deadlines, including rules relating to the disposition of benefits for Eligible Employees who fail to meet election deadlines;

3. Rules relating to the disposition of benefits for Participants who enter or exit the Plan during a Plan Year, or who experience an interruption of active service;

4. Rules relating to the administration of the various benefits contained within the Plan, including rules relating to the year-to-year availability of such benefits. Such rules may place restrictions on Participant access to nonelective or elective coverage if such restrictions are necessary to protect the financial well-being of the Plan, to comply with restrictions imposed by insurance carriers, or to preserve the status of the Plan as a cafeteria plan within the meaning of Section 125 of the Code.

~~M.~~ O. "Elective Contribution" means the amount allocated to specific Taxable Benefits and/or Nontaxable Benefits at the election of a Participant equal to a reduction in his Eligible Earnings pursuant to Section 5.28.240 B.

~~N.~~ P. "Eligible Earnings" means any compensation paid to an Eligible Employee for service performed for the County which is currently includible in gross income under the Code.

~~O.~~ Q. "Eligible Employee" means a full-time permanent employee of the County who is not in an Excluded Bargaining Unit and who is designated by the Board as eligible to participate in the Plan. For purposes hereof, "full-time permanent" means any employee appointed to an "A," "L" or "N" item pursuant to Title 6 of the Los Angeles County Code. "Eligible Employee" shall also mean any employee appointed to "D" item pursuant to said Title 6 who is required to possess a California license to practice as a Registered Nurse or an employee of the County appointed to a monthly temporary training "M" item pursuant to Title 6 of the Los Angeles County Code who is not in an Excluded Bargaining Unit and who is designated by the Board as eligible to participate in the Plan. However, the County and representatives of an Excluded Bargaining Unit may, subject to approval by the Los Angeles County Board of Supervisors, agree that any employee who would otherwise cease to be an Eligible Employee because of certification or accretion of the employee' s employment classification into an Excluded Bargaining Unit may continue as an Eligible Employee for such period as may be established in such agreement.

~~P.~~ R. "Eligible Participant" means a Participant who becomes disabled as a direct consequence and result of injury or disease.

~~Q.~~ S. "Evidence of Disability" means a statement of medical certification of disability submitted by a Physician to the Claims Administrator.

~~R.~~ T. "Excluded Bargaining Unit" means an employee representation unit, unless the representative of such unit and the County agree that the employees in such unit shall be covered hereunder.

U. "LTD Health Insurance Benefit" means a benefit that pays for 75 percent or 100 percent of the cost of Applicable Health Insurance Coverage at the time such coverage is provided pursuant to the rules in section 5.28.450.

V. "LTD Health Survivor" means a spouse, domestic partner as defined in Section 298.5 of the California Family Code, or dependent child (including a stepchild or adopted child) who is under age 19 or who is a full-time student under age 25, of (1) an Eligible Participant who dies while receiving or entitled to receive disability benefits under section 5.28.460; or (2) a Covered Employee who dies as a direct consequence and result of injury of disease; provided, however, that to be an LTD Health Survivor, an individual must be a spouse, domestic partner or dependent child who is covered by a County-sponsored medical plan offered under the Cafeteria Plan at the time of: (i) the onset of a total disability as determined by the Claims Administrator, or (ii) if the Covered Employee dies before he makes a claim for disability under the LTD Plan, the date of death.

~~S.~~ W. "Materials" means the booklets, manuals, handbooks, contracts, plan documents or sections thereof and other provisions of the Los Angeles County Code relating to the County-sponsored or County-approved employee benefit plans approved for inclusion in Subdivision 2 of the Plan by the Board.

X. "Medical Dependent" means a Covered Employee's spouse, domestic partner or dependent child who is eligible to be covered under the terms of a County-sponsored medical plan.

~~T.~~ Y. "Nonelective Contribution" means the amount available for allocation to particular Taxable Benefits and/or Nontaxable Benefits or for receipt as additional Eligible Earnings by a Participant pursuant to Section 5.28.240 A.

~~U.~~ Z. "Nonindustrial" means an injury or disease that the chief administrative officer or the workers' compensation appeals board has not yet determined to be compensable under the workers' compensation laws of the state of California or an injury or disease which has been determined not to be so compensable.

~~V.~~AA. "Nontaxable Benefit" means participation in any employee benefit program provided or sponsored by the County, insured or uninsured, now existing or hereafter adopted, for inclusion in the plan the cost of which is excludible from the gross income of the Participant pursuant to Sections 79, 105, 106, or 129 of the Code or any other applicable Code section, as the same may be amended.

~~W.~~BB. "Participant" means any Eligible Employee or former Employee who meets the requirements for participation in the Plan set forth in Section 5.28.230.

~~X.~~CC. "Physician" means any physician, surgeon, osteopath, psychiatrist, psychologist, chiropractor or other medical practitioner who is duly licensed by the state in which he practices and who is practicing within the scope of his license.

~~Y.~~DD. "Plan" means the County of Los Angeles Flexible Benefit Plan, as set forth in this Subdivision 2, as the same may be amended or restated from time to time.

~~Z.~~EE. "Plan Year" means the calendar year.

~~AA.~~FF."Retirement Plan A, B, C, or D Member" means an Eligible Employee or a Participant who is covered by any of the contributory retirement plans established for

general or safety members of the Los Angeles County Employees Retirement Association pursuant to the County Employees Retirement Law of 1937. For the sole purpose of determining entitlement to Nonelective Contributions and Nontaxable Benefits and Taxable Benefits provided under the Plan, an Eligible Employee or Participant employed on a monthly temporary training "M" item basis pursuant to Title 6 of the Los Angeles County Code shall be treated as if he were a Retirement Plan A, B, C, or D Member. In no event shall such Eligible Employee or Participant be entitled to any benefit under the County Employees Retirement Law of 1937 by reason of this treatment.

~~BB.~~GG. "Retirement Plan E Member" means an Eligible Employee or a Participant who is covered by the optional noncontributory retirement plan made operative for general members of the Los Angeles County Employees Retirement Association on or after July 1, 1981.

~~CC.~~HH. "SIB Compensation" means an SIB Participant' s Compensation in the month preceding his death, or the commencement of benefits under the LTD Plan, whichever occurs first.

~~DD.~~II. "SIB Participant" means a Retirement Plan E Member who is:

1. A Participant who has elected coverage under the SIB Plan for the current Plan Year; or

2. A former Participant who is disabled and receiving benefits under the LTD Plan, and who elected coverage under the SIB Plan for the Plan Year in which his LTD benefits commenced.

~~EE.~~JJ. "Taxable Benefit" means participation in certain health or welfare programs provided or sponsored by the County, insured or uninsured, now existing or hereafter adopted, described in the Materials, the cost of which will be treated by the County as includible in the gross income of the Participant pursuant to the Code as the same may be amended.

~~FF.~~KK. "Total Disability" or "Totally Disabled" means during the Waiting Period and during the subsequent 24-month period for which a Participant might be eligible to receive benefits under the LTD Plan, the complete and continuous inability and incapacity of the Participant to perform the duties of his position with the County. After the expiration of 24 consecutive months of eligibility for benefit payments, "Total Disability" or "Totally Disabled" means the Participant is Disabled within the meaning of the Federal Social Security Act and is eligible to receive or is receiving disability benefits under the Federal Social Security Act; provided, however, that for a participant who makes timely application for disability benefits under the Federal Social Security Act and who has not received a final determination regarding disability under the Act, "Total Disability" or "Totally Disabled" (for the period prior to the date on which a final determination is made regarding disability) shall mean the complete and continuous inability and incapacity of the Participant to perform the duties of his position with the County. A Participant who is not insured for disability benefits under the Federal Social Security Act (such as lacking sufficient quarters of covered employment) shall be considered Totally Disabled at the end of the 24-month period of eligibility for benefit

payments and during the continuance thereafter of the disability if he is disabled within the meaning of Section 223(d) of the Federal Social Security Act.

~~GG.~~LL.1. "Waiting Period" for purposes of the Short-Term Disability Plan means that a waiting period shall be required with respect to any one Disability, and that such period shall be a continuous period equal to 14 days, except as reduced by elective option. The Waiting Period shall commence with the first day the Participant is Disabled, and shall continue during the time he remains Disabled.

2. "Waiting Period" for purposes of the Long-Term Disability Plan means that a waiting period shall be required with respect to any one Total Disability, and shall be a continuous period equal to six months, commencing with the first day on which an eligible employee is absent from work due to a total disability, and during which he or she remains totally disabled except as provided below. If the eligible employee ceases to be totally disabled and returns to work for less than an aggregate of 30 days during a waiting period, any such cessation of total disability shall not interrupt continuity or extend the duration of the waiting period used to determine the first day on which benefits commence, provided that the successive absences during the waiting period are due to the same cause. The waiting period shall not include any time prior to January 1, 1991.

3. The continuity of the Waiting Period shall not be interrupted, nor shall the Waiting Period be extended, merely because an Eligible Participant incurs a disability during such period that arises from a different and unrelated cause than that which initially caused the Eligible Participant to be absent from work.

4. The Election Information may establish rules under which an Eligible Participant may return to work on a trial basis during the Waiting Period without causing any interruption or extension of said period.

SECTION 7. Section 5.28.240 is hereby amended to read as follows:

5.28.240 Contributions.

A. Nonelective Contributions.

1. Except as otherwise provided herein, each month the County shall contribute to the Plan on behalf of each Participant an amount equal to the greater of ~~$918.00~~$987.00 beginning the ~~2007~~2008 Plan Year or the amount designated in subsection A1a or b below, whichever is applicable:

...

SECTION 8. Section 5.28.450 is hereby amended to read as follows:

5.28.450 Election and benefit costs.

A. Nonelective Coverage. Each Retirement Plan E Member who has completed five or more years of continuous service as of the commencement of the current Plan Year, shall be entitled to nonelective LTD coverage equal to his Basic Monthly Compensation multiplied by 40 percent.

B. Elective Coverage.

1. Each Retirement Plan A, B, C, or D Member may elect LTD coverage equal to his Basic Monthly Compensation multiplied by 40 percent, or 60 percent.

2. Each Retirement Plan E Member who has less than five years of continuous service as of the commencement of the Plan Year for which he is eligible to make an election, may elect LTD coverage equal to his Basic Monthly Compensation multiplied by 40 percent, or 60 percent.

3. Each retirement Plan E Member who has five or more years of continuous service as of the commencement of the Plan Year for which he is eligible to make an election, may elect LTD coverage equal to his Basic Monthly Compensation multiplied by 60 percent.

~~4. LTD Health Insurance.~~

~~a. Each Eligible Employee or Participant may elect a disability health insurance benefit hereinafter referred to as "LTD Health Insurance." LTD Health Insurance shall provide health insurance coverage on a concurrent basis with the payment of benefits under Section 5.28.460. For each Eligible Employee or Participant who elects this option, LTD Health Insurance shall provide the employee with the health insurance coverage to which the Eligible Employee or Participant would otherwise be entitled as an active employee pursuant to the rules set forth in the Election Information and shall provide a subsidy toward the payment of that coverage equal to 75 percent of the total premium cost at the time the coverage is provided. The Eligible Employees and Participants receiving this subsidy shall pay the remaining 25 percent of the premium cost. Effective on January 1, 2005, LTD Health Insurance will be extended to the survivor of an employee who is participating in the LTD Health Insurance protection program. A "survivor," for this purpose, shall mean a spouse, domestic partner as~~

~~defined in Section 298.5 of the California Family Code, or dependent child as defined in the Election Information; provided, however, that no person shall receive LTD Health Insurance survivor benefits under this provision if he or she was not an eligible survivor as of the onset of disability as determined by the Claims Administrator or date of death where death occurs with no preceding claim for disability benefits by the Eligible Employee or Participant under the LTD Plan.~~

~~b. For new disabilities beginning on or after January 1, 2007, the LTD Health Insurance Benefits set forth in paragraph (a) above shall be applicable on a nonelective basis for all Participants otherwise eligible for LTD benefits. In addition, Eligible Employees and Participants may elect a 100 percent LTD Health Insurance benefit which shall provide a subsidy toward the payment of the health insurance coverage to which the Participant would otherwise be entitled as an active employee equal to 100 percent of the total premium cost at the time the coverage is provided. The Eligible Employees and Participants electing this subsidy shall pay nothing toward the premium cost at the time the health insurance is actually received. Other rules regarding LTD Health Insurance benefit eligibility shall include the following:~~

~~1. For the 2007 Plan Year and for each Plan Year thereafter, any Eligible Employee or Participant who does not elect the optional 100 percent LTD Health Insurance benefit shall be ineligible to make such election for the following Plan Year. The Eligible Employee or Participant must wait two Plan Years before again being eligible to elect this option.~~

~~2. In the event a Participant retires and becomes eligible to receive retiree health insurance from LACERA, LTD Health Insurance benefits will cease.~~

~~3. An Eligible Employee or Participant who elects to buy the 100 percent LTD Health Insurance benefit while receiving LTD benefits or while in the Waiting Period shall be limited to the 75 percent nonelective LTD Health Insurance benefit and shall not be eligible to receive the 100 percent elective LTD Health Insurance benefit with respect to that same disability until the employee returns to active employment for six months or more.~~

~~4. Such other benefit eligibility rules as may be determined necessary by the Chief Administrative Officer and set forth in the Election Information for the prudent administration of the LTD Health Insurance program.~~

4. LTD Health Insurance Benefit.

a. Benefits for Eligible Employees.

(1) For disabilities incurred prior to January 1, 2007, if the Covered Employee timely elects and pays for the 75 percent LTD Health Insurance Benefit in accordance with the terms of the Plan, the Covered Employee is covered by an LTD Health Insurance Benefit that pays for 75 percent of the cost of Applicable Health Insurance Coverage for the employee and his Medical Dependents during the period described in section 5.28.450B.4.c. The Covered Employee must make monthly contributions to purchase the 75 percent LTD Health Insurance Benefit, in amounts determined by the County, in accordance with the terms of the Plan. The

remaining 25 percent of the cost of Applicable Health Insurance Coverage elected by the employee shall be paid for by monthly employee payments in the time and manner determined by the County when the medical insurance coverage is received. Applicable Health Insurance Coverage will not be provided unless the employee timely remits his or her share of the cost for such coverage.

(2) For disabilities incurred on or after January 1, 2007, unless a Covered Employee makes the election provided in section 5.28.450B.4.a.(3), he is automatically covered, at no cost, by an LTD Health Insurance Benefit that pays for 75 percent of the cost of Applicable Health Insurance Coverage for the employee and his Medical Dependents during the period described in section 5.28.450B.4.c. The remaining 25 percent of the cost of any Applicable Health Insurance Coverage elected by the employee shall be paid for by monthly employee payments in the time and manner determined by the County when the medical insurance coverage is received. Applicable Health Insurance Coverage will not be provided unless the employee timely remits his or her share of the cost for such coverage.

(3) Beginning January 1, 2007, for disabilities incurred after that date, if the Covered Employee timely elects and pays for the 100 percent LTD Health Insurance Benefit in accordance with the terms of the Plan, the Covered Employee is covered by an LTD Health Insurance Benefit that will pay for 100 percent of the cost of Applicable Health Insurance Coverage for the employee and his Medical Dependents during the period described in section 5.28.450B.4.c. The Covered

Employee must make monthly contributions to purchase the 100 percent LTD Health Insurance Benefit, in amounts determined by the County, in accordance with the terms of the Plan.

b. Benefits for LTD Health Survivors

(1) Each LTD Health Survivor with respect to a Covered Employee described in section 5.28.450.B.4.a.(1) or (2) shall receive an LTD Health Insurance Benefit that pays for 75 percent of the cost of Applicable Health Insurance Coverage for that LTD Health Survivor during the period described in section 5.28.450B.4.c. The remaining 25 percent of the cost of any Applicable Health Insurance Coverage provided to the LTD Health Survivor shall be paid for by monthly payments by that individual in the time and manner determined by the County when the medical insurance coverage is received. Applicable Health Insurance Coverage will not be provided unless the covered individual timely remits his or her share of the cost for such coverage.

(2) Each LTD Health Survivor with respect to an Eligible Employee or Participant who elects and purchases the 100 percent LTD Health Insurance Benefit as described in section 5.28.450.B.4.a.(3) shall receive an LTD Health Insurance Benefit that pays for 100 percent of the cost of Applicable Health Insurance Coverage for that LTD Health Survivor during the period described in section 5.28.450B.4.c.

c. Duration of the LTD Health Insurance Benefit. The LTD Health Insurance Benefit shall be provided: (1) in the case of benefits provided under Section 5.28.450B.4.a., during the period that total disability benefits are paid under Section 5.28.460; and (2) in the case of benefits provided under Section 5.28.450B.4.b., until the LTD Health Survivor's death or until the individual no longer qualifies as an LTD Health Survivor; provided, however, that, in the event an individual receiving LTD Health Insurance Benefits becomes eligible to receive any retiree health insurance coverage from the Los Angeles County Employees Retirement Association (whether or not he or she elects to receive that insurance coverage), that individual's LTD Health Insurance Benefits will cease.

d. Limitations. Notwithstanding any other provision governing the LTD Health Insurance Benefit:

(1) To be eligible to receive an LTD Health Insurance Benefit, a Covered Employee, Medical Dependent or LTD Health Survivor must be covered under a County-sponsored medical plan offered through the Cafeteria Plan at the time the LTD Health Insurance Benefit commences; provided, however, that an employee receiving an LTD Health Insurance Benefit may elect to cover a Medical Dependent during open enrollment in accordance with Plan rules or to the extent otherwise required by applicable law.

(2) Any eligible employee receiving disability benefits under this Chapter 5.28 or completing the Waiting Period: (1) shall not be entitled to become covered by (if not already covered), or elect to increase the level of, the LTD Health Insurance Benefit unless and until the employee returns to work as a Covered Employee, and (2) will not be entitled to become covered by (if not already covered), or elect to increase the level of, the LTD Health Insurance Benefit with regard to that same disability unless and until the employee returns to active employment as a Covered Employee for at least 6 months. Additionally, any Covered Employee who does not elect the optional 100 percent LTD Health Insurance Benefit shall be ineligible to make such election for the following Plan Year. The Covered Employee must wait two Plan Years before again being eligible to elect this option.

e. Additional benefit eligibility rules may be determined as necessary by the Chief Executive Officer for the prudent administration of the LTD Health Insurance Benefit program and set forth in the applicable Cafeteria Plan documents and materials.

C. Cost. Nonelective LTD coverage shall be provided at no cost to the affected Participants. Elective LTD coverage, including elective LTD Health Insurance, shall require contributions from the affected Participants as provided for in the Election Information.

SECTION 9. Chapter 5.29 which was the County of Los Angeles Dependent Care Reimbursement Plan is hereby deleted in its entirety.

SECTION 10. Chapter 5.29 is hereby added to read as follows:

Chapter 5.29

The County of Los Angeles Non-Represented Employees' Dependent Care Reimbursement Plan

SECTIONS:

5.29.010 Purpose.

5.29.020 Definitions.

5.29.030 Participation and coverage.

5.29.040 Contributions and funding.

5.29.050 Dependent care expense reimbursement benefit.

5.29.060 Procedures.

5.29.070 Plan administration.

5.29.080 Plan administration or termination.

5.29.090 Miscellaneous provisions.

5.29.010 Purpose.

The County of Los Angeles Non-Represented Employees' Dependent Care Reimbursement Plan (the "Plan") was originally effective as of January 1, 1985 and was formerly known as the County of Los Angeles Dependent Care Reimbursement Plan. This amendment and restatement of the Plan is effective as of January 1, 2008, unless otherwise provided herein.

The Plan is designed to reimburse Qualifying Dependent Care Expenses of Covered Employees and is intended to qualify as a dependent care assistance plan under Code Section 129. Employee contributions to the Plan are made through the County of Los Angeles Flexible Benefit Plans, set forth in subdivisions 1 and 2 of Los Angeles County Code Chapters 5.27 and 5.28, the provisions of which are incorporated by reference into this Plan to the extent applicable. County contributions may be made as provided under the terms of this Plan.

5.29.020 Definitions.

A. "Annual Contribution Credits" means the total amount of Employer Contributions and Employee Contributions credited to a Covered Employee's Dependent Care Account for a Plan Year.

B. "Annual Enrollment" means the period before the start of each Plan Year during which Eligible Employees may elect to participate in the Cafeteria Plan and the programs offered thereunder, including this Plan, for that Plan Year.

C. "Cafeteria Plan" means each pensionable and nonpensionable County of Los Angeles Flexible Benefit Plan established under subdivisions 1 and 2 of Chapters 5.27 and 5.28 of the Los Angeles County Code, as applicable.

D. "Claims Administrator" means the person or entity, if any, to whom the Plan Administrator delegates claims administration, including responsibility for:

1. receiving and reviewing claims for Plan benefits,

2. determining benefit amounts payable,

3. disbursing benefit payments,

4. reviewing denied claims, and

5. determining appeals, under the terms and conditions of a written agreement with the Plan Administrator.

E. "Code" means the Internal Revenue Code of 1986, as amended.

F. "County" means the County of Los Angeles.

G. "Coverage Period" means the period within each Plan Year during which a Covered Employee is covered for any incurred Qualifying Dependent Care Expenses. The Coverage Period for each Plan Year begins: (1) in the case of an Employee who becomes an Eligible Employee and enrolls pursuant to Section 5.29.030A.1 prior to Annual Enrollment, on the first day of the month following the date the Employee completes the enrollment process, and (2) following enrollment during an Annual Enrollment pursuant to Section 5.29.030A.2, the first day of the next following Plan Year, and continues for the remainder of the Plan Year; provided, however, that a Coverage Period does not include any period after which coverage has terminated or during which coverage is suspended in accordance with 5.29.030.

H. "Covered Employee" means an Eligible Employee who satisfies the enrollment, participation and coverage requirements of 5.29.030.

I. "Dependent Care Account" means the record-keeping account established by the Plan Administrator pursuant to Section 5.29.060B for each Eligible Employee who elects coverage under this Plan.

J. "Dependent Care Center" means a facility which provides care for more than six individuals (other than individuals who reside at the facility) and receives a fee, payment, or grant for providing services to any of the individuals.

K. "Earned Income" means wages, salaries, tips, other compensation, and net earnings from self-employment (as defined and limited by Code Section 32(c)(2)), but does not include amounts paid or incurred by an Employer for dependent care assistance to a Covered Employee. A spouse of a Covered Employee shall, for each month that spouse is a Full-Time Student or Incapable of Self-Care, be deemed to be gainfully employed and to have Earned Income of not less than $250 per month if the Covered Employee has one Qualifying Dependent and $500 per month if the Covered Employee has two or more Qualifying Dependents.

L. "Effective Date" of this Plan as amended and restated is January 1, 2008.

M. "Eligible Employee" means an Employee who is an eligible employee under the terms of a Cafeteria Plan and who works at least 8 hours or receives 8 hours of leave benefits in the prior calendar month.

N. "Employee" means any person who has been determined by the Employer (regardless of any determination made by any other person or entity) to be currently an employee of the Employer for federal income and/or employment tax purposes. The

term Employee does not include any individual who has been classified by the Employer as an independent contractor or leased employee, except to the extent leased employees within the meaning of Code Section 414(n) must be taken into account in applying nondiscrimination testing required under the Code. In the event that the Internal Revenue Service, another governmental agency with the authority to make a reclassification, or a court of competent jurisdiction, issues a final, binding decision that one or more individuals should be reclassified as employees for federal income and/or employment tax purposes, the Employer may change the status of such individuals to Employees effective as of a date determined by the Employer following such decision.

O. "Employee Contribution" means a contribution made to the Plan in accordance with Section 5.29.040A.1.

P. "Employer" means the County and (1) any governmental entity of which the Los Angeles County Board of Supervisors is the governing body, (2) the Los Angeles County Superior Court to the extent participation is otherwise authorized by state law or rules of court, and (3) any related Employer which has adopted this Plan as a Participating Employer as described in Section 5.29.90.

Q. "Employer Contribution" means a contribution made to the Plan in accordance with Section 5.29.040A.2.

R. "Full-Time Student" means an individual who during each of five calendar months of the Plan Year is a full-time student at an educational organization.

S. "Incapable of Self-Care" means that, due to physical or mental problems,

an individual is incapable of caring for his hygienic or nutritional needs, or requires full-time attention of another person for his own safety or the safety of others.

T. "Maximum Annual Benefit" means, with respect to any Plan Year, the lesser of

1. $4,800 ($2,500 for a married individual filing a separate federal income tax return),

2. the Covered Employee's Earned Income for the Plan Year, or

3. if the Covered Employee is married at the end of the Plan Year, the Earned Income of the Covered Employee's spouse for the Plan Year.

U. "Participating Employer" means Employer which adopts this Plan in accordance with Section 5.29.90.

V. "Plan" means the County of Los Angeles Non-Represented Employees' Dependent Care Reimbursement Plan, as amended from time to time.

W. "Plan Administrator" means the person, entity, or committee appointed according to Section 5.29.070.A, who is responsible for managing the Plan's operation and administration. If a Plan Administrator is not appointed, the County shall serve as Plan Administrator.

X. "Plan" Year means the 12-month period beginning January 1 and ending December 31.

Y. "Qualifying Dependent" means any of the following who has the same

principal place of abode as the Covered Employee for more than half of the calendar year:

1. a qualifying child (as defined in Code Section 152(c)) of the Covered Employee who is under the age of 13, and

2. a spouse or other dependent (as defined in Code Section 152, determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B)) of the Covered Employee who is Incapable of Self-Care. Notwithstanding the foregoing, if Code Section 152(e) applies to a child who is under age 13 or is Incapable of Self-Care, he shall be treated as a Qualifying Dependent of the Covered Employee if the Covered Employee is the custodial parent (as defined in Code Section 152(e)(4)(A)).

Z. "Qualifying Dependent Care Expenses" has the meaning set forth in Section 5.29.050.

AA. "Status Change" means:

1. a change in legal marital status, including marriage, death of spouse, divorce, legal separation, or annulment;

2. a change in the number of dependents, including birth, adoption, placement for adoption, or death of a dependent;

3. a change in employment status of the Eligible Employee or the Eligible Employee's spouse, including an increase or decrease in the number of hours of employment by the Eligible Employee or spouse, a change in worksite, a strike or

lockout, or commencement or return from an unpaid leave of absence;

4. a dependent satisfying or ceasing to satisfy the requirements for being a Qualifying Dependent, unless the dependent's ceasing to satisfy such requirements is due solely to attainment of age 13; and

5. any other event the Plan Administrator determines permits revocation of an election under Code Section 125 and the regulations, rulings or other guidance issued thereunder.

5.29.030 Participation and coverage.

A. Enrollment.

1. Initial Enrollment. An individual who first becomes an Eligible Employee after the Effective Date but prior to an Annual Enrollment initially may participate in the Plan by completing the Cafeteria Plan enrollment process within the 60-day period beginning on the date the Employee becomes an Eligible Employee. Coverage for an Eligible Employee who enrolls in accordance with this Section shall be effective on the first day of the calendar month next following the date he completes the Cafeteria Plan enrollment process; provided, however, that an Eligible Employee who completes enrollment during November will not participate until the start of the next Plan Year. Except as provided in section 5.29.030A.3, if an Eligible Employee fails to enroll, he or she will not participate in the Plan for the remainder of the Plan Year.

2. Annual Enrollment. Prior to the beginning of each Plan Year, the

Plan Administrator will conduct an Annual Enrollment, during which Eligible Employees may make new elections or change existing elections effective for the next following Plan Year. An Eligible Employee may become or continue to be a Covered Employee under this Plan by completing the Annual Enrollment process by the end of the Annual Enrollment period established by the Plan Administrator. Coverage elected under this Plan during an Annual Enrollment shall be effective as of the first day of the Plan Year following the Annual Enrollment. If an Eligible Employee fails to enroll, he or she will not participate in the Plan for the next following Plan year.

3. Change in Employment Classification During Plan Year.

a. If a participant in the Choices or Options Dependent Care Reimbursement Plan for a Plan Year ceases to be eligible thereunder but becomes an Eligible Employee under this Plan during that Plan Year, he will have the opportunity to enroll in this Plan under Section 5.29.030A.1, provided, however, that his coverage under this Plan will not become effective until the first day of the second month following the date he completes the enrollment process. If he fails to complete the enrollment process within the 60-day period described in Section 5.29.030A.1, he will automatically become a Covered Employee under this Plan effective as of the first day of the second month after the 60-day enrollment period ends, and his election regarding the level of his Employee Contributions under the Choices or Options Dependent Care

Reimbursement Plan will continue in effect under this Plan for the remainder of the Plan

Year.

b. If a Covered Employee ceases to be a Covered Employee and becomes eligible to participate in the Choices or Options Dependent Care Reimbursement Plan during a Plan Year, he will have a 60-day period in which to complete the enrollment process for that plan; provided, however that his coverage under the Choices or Options Dependent Care Reimbursement Plan will not become effective until the first day of the second month following the date he completes the enrollment process. If he fails to complete the enrollment process within the 60-day period, he will automatically begin participating in the Choices or Options Dependent Care Reimbursement Plan, as applicable, effective as of the first day of the second month after the 60-day enrollment period, and his election regarding the level of Employee Contributions under this Plan will continue in effect under the Choices or Options Dependent Care Reimbursement Plan, as applicable, for the remainder of the Plan Year.

4. Enrollment Information and Deadlines. In order to complete the enrollment process during initial enrollment or Annual Enrollment as described in this Section 5.29.030, an Eligible Employee shall specify the amount of Employee Contributions, if any, to be credited to his Dependent Care Account and the corresponding Annual Contribution Credits for the Plan Year, and shall provide any other information required by the Plan Administrator. The form and content of any enrollment materials, and any limitations with respect to the time for completing the

enrollment process, shall be determined by the Plan Administrator and communicated to Eligible Employees prior to enrollment.

5. Limits. The maximum Annual Contribution Credits that may be elected under the Plan for any Plan Year is the Maximum Annual Benefit as defined in Section 5.29.020T. The amount that may be excluded from the gross income of a Covered Employee and his spouse, if any, with regard to Qualifying Dependent Care Expenses reimbursed under this Plan or any other dependent care reimbursement plan in any calendar year shall be limited in accordance with Code Section 129.

B. Coverage.

1. Initial Coverage. An Eligible Employee may become a Covered Employee during a Plan Year as of the first day of the calendar month next following the date he completes the Cafeteria Plan enrollment process in accordance with Section 5.29.030A.1. Except as otherwise provided in this Section 5.29.030, coverage shall remain effective for the balance of the Plan Year.

2. Annual Enrollment. Prior to the beginning of each Plan Year, the Plan Administrator will conduct an Annual Enrollment, during which Eligible Employees may make new elections or change existing elections effective as of the first day of the next following Plan Year. Except as otherwise provided in this Section 5.29.030, benefit elections shall remain effective for the entire Plan Year.

3. Change in Employment Classification During Plan Year. An

Eligible Employee who enrolls or is defaulted into coverage in accordance with Section 5.29.030A.3.a. shall become a Covered Employee as of the first day of the second calendar month after either (a) the date he completes enrollment or, (b) if he is defaulted into the Plan, the end of the 60-day enrollment period. Except as otherwise provided in this Section 5.29.030, coverage shall remain effective for the balance of the Plan Year.

4. Coverage During Leave of Absence or When Not Receiving Pay. A Covered Employee's coverage under the Plan shall continue while he is on a paid or unpaid leave of absence even if no Employer Contributions or Employee Contributions are credited to his Dependent Care Account during that period; provided, however, that the Covered Employee's Annual Contribution Credits will be reduced to reflect any Employee Contributions and Employer Contributions that are not made during that period.

C. Termination of Coverage.

1. Date Coverage Ceases. Plan coverage ceases upon the earliest to occur of:

a. the first day of the second month immediately following the date the Covered Employee ceases to be an Employee or an Eligible Employee, unless the Covered Employee has changed employment classification and plan participation during the Plan Year as described in Section 5.29.030A.3.b,

b. in the case of a Covered Employee who changes

employment classification and plan participation during the Plan Year as described in Section 5.29.030A.3.b, the first day of the second month following the earlier of (1) the date he completes the enrollment process under the Choices of Options Dependent Care Reimbursement Plan, or (2), the end of the 60-day enrollment period,

c. the effective date of the Covered Employee's election not to participate, or failure to elect to participate, in the Plan under Section 5.29.030A.1 or 2

d. the effective date of any Plan amendment that terminates coverage for the Covered Employee's job category, or

e. the date of Plan termination.

2. Effect of Termination of Coverage. No benefits are payable for Qualifying Dependent Care Expenses incurred after Plan coverage terminates (and before the date, if any, that it is reinstated).

D. Revoking and Changing Elections.

1. General Rule. Except in extraordinary circumstances described in this subsection D, benefit elections shall be irrevocable for the Plan Year for which they are made. Any new benefit election made under this subsection D must be made within 90 days beginning on the date of the event that is the reason for the new election. Any new benefit election shall be effective on the first day of the month following the correct and timely completion and submission of all required forms. This subsection D shall be interpreted and applied in accordance with applicable Treasury regulations and in a

nondiscriminatory manner in accordance with Code Sections 125 and 129.

2. Revocation of Elections for Status Change; Consistency Rule.

a. General Rule. The Plan Administrator may, in its discretion, permit (i) a Covered Employee to revoke a benefit election under the Plan and make a new benefit election or (ii) an Eligible Employee who is not participating in the Plan to make a benefit election and commence participation in the Plan, if a Status Change occurs and the election change or new election satisfies the consistency requirements described in subparagraph 2.b below.

b. Consistency Rules. An election change or new election satisfies the requirements of this paragraph if the election change or new election is on account of and corresponds with a Status Change that affects (i) eligibility for coverage under an Employer's dependent care reimbursement account plan, or (ii) expenses described in Code Section 129.

3. Cost Changes.

a. Significant Cost Changes. If the cost of a Covered Employee's Qualifying Dependent Care Expenses significantly increases or significantly decreases during a Plan Year, or if the cost to the Employee (e.g., the necessary level of Employee Contributions) to maintain the elected Annual Contribution Credits for the Plan Year increases due to the reduction or termination of Employer Contributions under Section 5.29.040A.2, the Plan Administrator, in its discretion, may permit any affected Covered Employee to revoke his existing election and make a new election to

reflect the increased or decreased cost.

b. Limitation. Notwithstanding anything to the contrary in this Section 5.29.030D.3, no election changes under the Plan shall be permitted as a result of a change in cost for Qualifying Dependent Care Expenses imposed by a dependent care provider unless such change in cost is imposed by a dependent care provider who is not a qualifying relative (as defined in Code Section 152(d)) of the Covered Employee.

4. Significant Improvement or Curtailment of Coverage (Services). If the dependent care services being provided to a Covered Employee are significantly improved or curtailed (e.g., if the entity or person providing dependent care services changes or if the hours of services provided change), the Plan Administrator, in its discretion may permit the Covered Employee to revoke his existing election and make a new election to reflect the cost of the modified services.

5. Change in Coverage Under Another Employer Plan. The Plan Administrator may permit a Covered Employee to prospectively change or revoke an existing benefit election under the Plan if the election change is on account of and corresponds with a change made under another Employer plan (including a plan of the same Employer or of another Employer) that would be permitted under this Section (without regard to this subsection 5). The Plan Administrator also may permit a Covered Employee to make a prospective election to drop coverage under the Plan if dropping such coverage is on account of and consistent with adding coverage under

another Employer's plan provided that the period of coverage or plan year under the plan does not correspond with the period of coverage or Plan Year under this Plan.

5.29.040 Contributions and funding.

A. Contributions.

1. Employee Contributions. During enrollment in accordance with Section 5.29.030, and pursuant to the terms of the Cafeteria Plan, an Employee may elect to have his Employer credit a portion of his Contribution (as defined in the Cafeteria Plan) to his Dependent Care Account. The amount elected may not be less than $10 or more than the amount that, together with any monthly Employer Contribution, would cause his Annual Contribution Credits to exceed the Maximum Annual Benefit. To the extent permitted under Code Sections 125 and 129, Employee Contributions will be treated like non-taxable Employer contributions.

2. Employer Contributions. Each Employer may contribute up to a designated dollar amount per month to the Plan on behalf of each Covered Employee employed by that Employer who elects to receive an Employer Contribution. The Employer shall determine the maximum amount of the monthly Employer Contribution that it will make on behalf of each Covered Employee, as well as any annual cap on total Employer Contributions, before the start of each Plan Year. The Plan Administrator shall disclose to Eligible Employees prior to enrollment the maximum level of Employer Contribution that may be made on behalf of each Covered Employee and the existence of the cap. A Covered Employee does not need to make Employee

Contributions to receive an Employer Contribution. An Eligible Employee who does not enroll in the Plan will not be entitled to an Employer Contribution.

In the event the Employer establishes an annual cap on Employer Contributions on behalf of Covered Employees, the Employer may, without prior notice to Covered Employees and at any time during the Plan Year, reduce or terminate the Employer Contribution to be made for some or all Covered Employees in any manner consistent with Code Section 129(d) that it determines is necessary to prevent the cap from being exceeded. The Plan administrator shall notify affected Covered Employees if their Employer Contributions will be reduced or terminated and their Annual Contribution Credits reduced due to imposition of a cap.

3. Termination or Suspension of Contributions. The Employer will not make an Employer Contribution or Employee Contribution for a month on behalf of a Covered Employee if he works less than 8 hours or receives less than 8 hours of leave benefits in the prior month. The Employer also will not make an Employer Contribution or Employee Contribution on and after the first day of the second month after the Covered Employee ceases to be an Employee or an Eligible Employee unless the Covered Employee changes employment classifications and plan participation as described in Section 5.29.030A.3.a. If the Covered Employee changes employment classifications and plan participation as described in Section 5.29.030A.3.a, he will not

receive an Employer Contribution or Employee Contribution on or after the date his

coverage under the Plan terminates in accordance with Section 5.29.030C.1.b.

B. Plan Funding. The Plan is not required to be and is not funded or insured. Benefits paid to a Covered Employee are paid solely out of the general assets of the Employee's Employer.

5.29.050 Dependent care expense reimbursement benefit.

A. Reimbursement of Qualifying Dependent Care. Subject to the terms and limits set forth in this Section 5.29.050, Covered Employees may be reimbursed for Qualifying Dependent Care Expenses as defined in Section 5.29.050B.

B. Qualifying Dependent Care Expenses Defined. Qualifying Dependent Care Expenses means expenses incurred by the Covered Employee for household services or for the care of a Qualifying Dependent but only if such expenses are incurred to enable the Covered Employee (and the Covered Employee's spouse, if any) to be gainfully employed or to search for gainful employment for any period for which there are one or more Qualifying Dependents with respect to the Covered Employee, and subject to the exclusions set forth in Section 5.29.050C. For these purposes:

1. A Covered Employee's spouse is deemed gainfully employed for each month that he is a Full-Time Student or is Incapable of Self-Care.

2. Volunteer work for a nominal salary does not constitute gainful employment.

3. Expenses paid for a period during only part of which a Covered

Employee or spouse is gainfully employed or in active search of gainful employment must be allocated on a daily basis, unless such expenses are incurred during a short, temporary absence from work (such as for vacation or minor illness) and the dependent care arrangement requires payment for care during the absence. An absence of two consecutive calendar weeks is deemed a short, temporary absence.

4. Expenses are for the care of a Qualifying Dependent only if their primary purpose is to assure the individual's well-being and protection. Expenses incurred for the care of a Qualifying Dependent may include employment taxes on the wages of a care provider, the additional costs of room and board for a care provider over usual household expenditures, and expenses that relate to, but are not directly for, the care of a Qualifying Dependent such as application fees, agency fees and deposits if the Covered Employee is required to pay those expenses to obtain the related care. Forfeited deposits or other payments are not for the care of a Qualifying Dependent if care is not provided in connection with those amounts.

5. Expenses are paid for household services if they are paid for the performance in and about the Covered Employee's home of ordinary and usual services necessary to the maintenance of the household, provided the expenses are attributable to the care of a Qualifying Dependent. Services of a housekeeper are household services if the services are provided, at least in part, to the Qualifying Dependent.

6. Expenses that are incurred for services outside the Covered

Employee's household may qualify as Qualifying Dependent Care Expenses only if such expenses are incurred for the care of a Qualifying Dependent described in subsection 5.29.020Y.1 of this Plan or any other Qualifying Dependent who regularly spends at least 8 hours each day in the Covered Employee's household.

7. Expenses that are incurred for services provided outside the Covered Employee's household by a Dependent Care Center may qualify as Qualifying Dependent Care Expenses only if such center complies with all applicable state and local laws and regulations applicable to such facility.

8. The cost of transportation by a care provider of a Qualifying Dependent to or from a place where care of the Qualifying Dependent is provided may be for the care of the Qualifying Dependent.

9. Qualifying Dependent Care Expenses are incurred on the date the dependent care is provided, not on the date charged, billed, or paid.

C. Exclusions. Notwithstanding any other provision of this Plan to the contrary, Qualifying Dependent Care Expenses do NOT include:

1. Any amounts paid for services outside the Covered Employee's household at a camp where the Qualifying Dependent stays overnight;

2. Expenses incurred in connection with services rendered by: (a) a Covered Employee's child or a child of the Covered Employee's spouse who is under the age of 19 as of the end of the Plan Year, or (b) a person who qualifies as a

dependent of the Covered Employee or a dependent of the Covered Employee's spouse and for whom a deduction is allowable under Code Section 151(c) to the Covered Employee or to the Covered Employee's spouse for the Plan Year.

3. The costs of a Qualifying Dependent's food, clothing, entertainment, or education (unless for a child below kindergarten) unless those costs are incidental, minimal, and inseparable from the cost of caring for a Qualifying Dependent.

4. The costs of transportation other than as provided in subsection 5.29.050B.8.

D. Coverage Period Limitations. Qualifying Dependent Care Expenses reimbursed by the Plan for a Plan Year must have been incurred during the Coverage Period. Accordingly, with regard to each Plan Year, the Plan will not reimburse any expenses incurred:

1. before the start of the Plan Year or after the end of the Plan Year,

2. before a benefit election becomes effective in accordance with Section 5.29.030, or

3. after coverage terminates or during a period in which coverage is suspended in accordance with Section 5.29.030.

E. Amount Payable. Reimbursement of Qualifying Dependent Care

Expenses may not exceed the Annual Contribution Credits elected for the Plan Year, or the balance credited to a Covered Employee's Dependent Care Account at the time such reimbursement is made. Any unused balance in a Covered Employee's Dependent Care Account after the claims period described in Section 5.29.060C has expired shall be forfeited.

F. Code Limitations on Benefits. Benefits payable under the Plan to each highly compensated Employee, as defined in Code Section 414(q), are limited to the extent necessary to avoid violating the nondiscrimination requirements contained in Code Section 129.

5.29.060 Procedures.

A. Enrollment and Election Procedures. Eligible Employees may enroll, specify the amount of his Employee Contributions and designate the corresponding Annual Contribution Credits for a Plan Year only by completing the enrollment procedure in accordance with Section 5.29.030. Upon initial eligibility and during Annual Enrollment, the Plan Administrator will provide all Eligible Employees with information about permissible benefit elections under the Plan and procedures for enrollment and benefit elections.

B. Dependent Care Accounts. The Plan Administrator shall establish a Dependent Care Account for each Covered Employee. Each Covered Employee's Dependent Care Account will be credited with Employee Contributions and/or Employer Contributions in accordance with Section 5.29.040, and will be debited by the amount of

any Qualifying Dependent Care Expenses paid or incurred on behalf of the Covered Employee under the Plan for the Plan Year. The amount of Qualifying Dependent Care Expenses payable from the Plan at any time shall be limited pursuant to Section 5.29.050E of the Plan. Any unused balance in a Covered Employee's Dependent Care Account after the claims period described in Section 5.29.060C has expired for any Plan Year shall be forfeited.

C. Claim Procedures. Any Covered Employee (or duly authorized representative) seeking Plan benefits shall assert a claim under the procedures of this Section regardless of the basis asserted for the claim or when the act or omission occurred on which the claim was based. The Plan Administrator or Claims Administrator will provide, upon request, forms required for filing a claim for Plan benefits and instructions on the information that must be submitted for the claim to be processed. The Plan Administrator shall determine the information that must be included in any claim submission. Such information may include, but is not limited to:

1. itemized bills or receipts,

2. the amount, date, and nature of the expense,

3. the name, address, social security number or tax identification number and signature of the provider,

4. the name of the person for whom the expense was incurred and the person's relationship to the Covered Employee,

5. the amount, if any, that has been reimbursed or is reimbursable from any other source, and

6. any other information required by the Plan Administrator.

Claimants must complete and file the appropriate forms with the Claims Administrator by June 30th following the close of the Plan Year to which the claim relates.

D. Claim Determination. The Plan Administrator or Claims Administrator shall determine all matters pertaining to claims for Plan benefits. If the Plan Administrator or Claims Administrator denies a Covered Employee's claim for benefits, the entity reviewing such claim shall notify the Covered Employee in writing of such denial within a reasonable period of time.

E. Claim Review Procedures.

1. Appeal Process. A Covered Employee may appeal an adverse benefit determination under the Plan to the Plan Administrator by filing an appeal to the Plan Administrator within 180 days of receiving notice of the adverse benefit determination. If the Plan Administrator upholds the adverse benefit determination on appeal, it shall provide written notification to the Covered Employee of such determination as soon as reasonably possible.

2. Determination Final. The Plan Administrator's decision on appeal shall be final and binding on all persons.

5.29.070 Plan administration.

A. Plan Administrator. The County of Los Angeles shall act as Plan Administrator except to the extent that it delegates its responsibilities in accordance with Section 5.29.070.

B. Plan Administrator's Duties. The Plan Administrator's duties include:

1. Management of Plan operations and administration according to the Plan's terms and for the exclusive benefit of Covered Employees;

2. Maintenance of:

a. records and data necessary or desirable for the Plan's proper operation and administration; and

b. governing documentation of the Plan for inspection by any Covered Employee under the Plan.

3. Notification of Eligible Employees of the Plan's availability and terms; and

4. Preparation and filing of all annual reports or returns, Plan descriptions, financial statements, and other documents required by law or under the Plan's terms.

C. Plan Administrator's Powers. The Plan Administrator may exercise, in a uniform and nondiscriminatory manner sole and absolute discretion in the Plan's operation and administration, including:

1. Establishment of such rules and regulations not inconsistent with the terms of the Plan as it deems necessary or proper for the efficient administration of the Plan and for the payment of benefits under the Plan;

2. Interpretation of the Plan, making decisions regarding all questions of the eligibility of persons to participate in the Plan and making factual determinations under the Plan, construction of any ambiguous provision of the Plan, correction of any defect, supplying any omission, or reconciliation of any inconsistency, in such manner and to such extent as the Plan Administrator in its discretion may determine, and any such action of the Plan Administrator will be binding and conclusive upon all Covered Employees;

3. Appointment of such agents, counsel, accountants, consultants, and other persons as may be required to assist in administering the Plan, including, without limitation, Employees of an Employer or a third-party Claims Administrator; and

4. Allocation and delegation of responsibilities under the Plan and designation of such departments, Employees, committees, entities, or persons including, without limitation, a third-party administrator (such as a third-party Claims Administrator), to carry out any of its responsibilities under the Plan.

D. Plan Administrator Determinations and Actions. The Plan Administrator shall use ordinary care and diligence in performing its duties.

1. Expenses and Compensation. Unless the County agrees otherwise, the Plan Administrator shall serve without compensation. The County shall pay all reasonable expenses the Plan Administrator incurs in performing its duties.

2. Indemnification. The County shall indemnify and hold harmless any Employee, officer, or director who serves or served as Plan Administrator from all claims, liability, and costs (including reasonable attorneys' fees) arising out of being the Plan Administrator or performing the Plan Administrator's duties, except if the claim, liability, or cost is the result of such individual's willful misconduct or bad faith.

5.29.080 Plan amendment or termination.

A. Permanence of the Plan; Right to Terminate. The Plan shall continue in full force and effect unless amended or terminated by the County as provided in Section 5.29.080B.

B. Plan Amendment or Termination to Amend or Terminate the Plan at Any Time. The County reserves the right to amend or terminate the Plan at any time.

C. Effect of Amendment or Termination; No Vested Rights. No amendment or termination of the Plan shall have any retroactive effect so as to deprive any Covered Employee of any benefit then payable. Notwithstanding the foregoing, amendment or termination of the Plan may be made retroactive to the extent necessary for the Plan to comply with any applicable law. No Covered Employee has any vested right to continue to receive benefits under the Plan.

5.29.090 Miscellaneous provisions.

A. No Employment Rights. Nothing contained in the Plan shall be construed as a contract of employment between an Employer and any Employee, or as the right of any Employee to continue in the employment of an Employer, to be employed for any specific period of time.

B. Exclusive Obligations and Rights. The County, an Employer, and the Plan Administrator do not have any obligation or duty other than as stated in the Plan and, except as specified in this document, no one has a right to Plan benefits or a legal or equitable right against the County, the Board of Supervisors, an Employer, the Plan, or the Plan Administrator.

C. No Assignment of Benefits. Except to the extent required in accordance with applicable law, Plan benefits are not subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, levy or charge of any kind, and any attempt to effect any of these actions is void.

D. Misrepresentation or Fraud. A Covered Employee who receives a Plan benefit as a result of false or incomplete information or a misleading or fraudulent representation shall repay all amounts the Plan paid and is liable for all collection costs including attorneys' fees and court costs.

E. Legal Action.

1. Exhaustion of Administrative Procedures. Before pursuing legal action, a person claiming Plan benefits or seeking redress related to the Plan shall first exhaust all claim, review and appeal procedures provided by the Plan. No action at law or in equity may be brought to recover Plan benefits or seek redress related to the Plan until the claim procedures contained in Section 5.29.060 have been exhausted.

2. Necessary Parties. Unless otherwise required by law, the County and the Plan Administrator are the only necessary parties to any action or proceeding that involves the Plan or its administration. No Employee, Employer or other person or entity is entitled to notice of any legal action, unless a court with appropriate jurisdiction orders otherwise.

F. Governing Law. The Plan's provisions and all Plan matters, including actions of the parties involved, are construed and enforced according to applicable California laws unless preempted by federal law.

G. Governing Instrument. This writing, together with any documentation incorporated by reference, is the legal instrument governing the Plan. In case of conflict between this document and any of the writings incorporated by reference, the provisions of the documentation govern in the following order: this document, any other plan document, any summary plan description, any enrollment or election form and, finally, any other writing. No writing or evidence may contradict or interpret the Plan's terms or provisions unless specifically incorporated by reference herein.

H. Savings Clause. If a Plan provision or its application is held invalid under governing law by a court of appropriate jurisdiction, the remainder of the Plan and its application will not be affected.

I. Parties' Liability. Neither the County, the Board of Supervisors, an Employer, the Plan Administrator, nor any delegate thereof, shall be liable for:

1. good faith reliance on any fact or absence of fact, good faith action, or good faith omission,

2. another person's act or omission, unless required by law, or

3. the tax consequences of contributions to or benefits paid from the Plan.

J. Tax Consequences Not Guaranteed. Neither the County, the Board of Supervisors, an Employer, the Plan, the Plan Administrator, nor any other person connected with any such person or entity guarantees that Plan benefits are or will be excludable from a Covered Employee's gross income for federal, state, or local income tax purposes, or that any other tax treatment is or will be applicable or available. Covered Employees themselves shall determine whether Plan benefits are excludable for these purposes, and shall notify the Plan Administrator if they have reason to believe a payment is not excludable. If the Plan Administrator determines at any time after the end of a Plan Year that contributions to the Plan or benefits paid exceeded limits allowed by law for any reason including, but not limited to, erroneous information,

administrative error or failure to satisfy prohibitions on discrimination, then affected Covered Employees shall:

1. pay any local, state, and federal income taxes and related penalties and interest due with respect to the excess contributions or benefits, and

2. reimburse the Employer for the Employee's share of any local, state, and federal tax contributions the Employer would have withheld or other applicable deductions the Employer would have taken had the excess contributions or benefits been treated as taxable income.

K. Nondiscrimination. If, in the judgment of the Plan Administrator, the Plan may fail to meet the requirements of Section 129(d) of the Code, the Plan Administrator will take such action as it deems appropriate to assure compliance with such requirements. The action taken by the Plan Administrator may include, without limitation, a modification of the elections of certain Covered Employees who are defined as "highly compensated employees" under Code Section 414(q). Such action may be taken by the Plan Administrator without consent of the affected Covered Employee.

L. Participating Employers. With the County's consent, any Employer may adopt or withdraw from this Plan. Each Participating Employer shall file with the Plan Administrator a notice of adoption specifying:

1. the effective date of its adoption, and

2. any other information the Plan Administrator may require to carry out its duties under the Plan. Except for functions reserved to the County, the Plan Administrator has exclusive authority over all Plan matters and acts as agent of all Employers that have at any time adopted the Plan.

An adopting Employer may withdraw from Plan participation by giving the County and the Plan Administrator 60 days advance written notice of its withdrawal. Similarly, the County may terminate an Employer's Plan participation by giving the Employer and the Plan Administrator 60 days advance written notice of the termination. Upon an Employer's withdrawal or termination of participation, the Plan Administrator must provide the Employer with copies of all records that the Plan Administrator determines necessary for the Employer to terminate and administer its portion of the Plan. An Employer's withdrawal or termination of Plan participation operates only as to that Employer's Employees.

SECTION 11. Section 5.33.040 is hereby amended to read as follows:

5.33.040 Contributions.

A. Nonelective Contributions.

1. Except as otherwise provided herein, for each month of the ~~2004~~ 2007 Plan Year (commencing with County pay warrants issued on or about January 15, ~~2004~~ 2007), the County shall contribute to the Plan on behalf of each Participant an amount equal to ~~$352.00~~ $438.90, unless (a) said Participant is entitled to Two Party Medical Insurance Coverage with respect to said month, in which case,

the County shall contribute an amount equal to ~~$633.00~~ $800.80; or (b) said Participant is entitled to Three Party Medical Insurance Coverage with respect to said month, in which case, the County shall contribute an amount equal to ~~$749.00~~ $946.00.

2. Except as otherwise provided herein, for each month of the ~~2005~~ 2008 plan Year (commencing with County pay warrants issued on or about January 15, ~~2005~~ 2008), the County shall contribute to the Plan on behalf of each Participant an amount equal to ~~$375.00~~ $482.79, unless (a) said Participant is entitled to Two Party Medical Insurance Coverage with respect to said month, in which case, the County shall contribute an amount equal to ~~$679.00~~ $880.88; or (b) said Participant is entitled to Three Party Medical Insurance Coverage with respect to said month, in which case, the County shall contribute an amount equal to ~~$802.00~~ $1,040.60.

3. Except as otherwise provided herein, for each month of the ~~2006~~ 2009 Plan Year (commencing with County pay warrants issued on or about January 15, ~~2006~~ 2009), the County shall contribute to the Plan on behalf of each Participant an amount equal to ~~$399.00~~ $531.07 unless (a) said Participant is entitled to Two Party Medical Insurance Coverage with respect to said month, in which case, the County shall contribute an amount equal to ~~$728.00~~ $968.97 or (b) said Participant is entitled to Three Party Medical Insurance Coverage with respect to said month, in which case, the County s hall contribute an amount equal to ~~$860.00~~ $1,144.66.

...

SECTION 12. Chapter 5.34 which was the Choices Dependent Care Spending Account is hereby deleted in its entirety.

SECTION 13. Chapter 5.34 is hereby added to read as follows:

Chapter 5.34

Choices Dependent Care Reimbursement Plan

Sections:

5.34.010 Purpose.

5.34.020 Definitions.

5.34.030 Participation and coverage.

5.34.040 Contributions and funding.

5.34.050 Dependent care expense reimbursement benefit.

5.34.060 Procedures.

5.34.070 Plan administration.

5.34.080 Plan amendment or termination.

5.34.090 Miscellaneous provisions.

5.34.010 Purpose.

The Choices Dependent Care Reimbursement Plan (the "Plan") was originally effective as of July 1, 1989. This amendment and restatement of the Plan is effective as of January 1, 2008, unless otherwise provided herein.

The Plan is designed to reimburse Qualifying Dependent Care Expenses of Covered Employees and is intended to qualify as a dependent care assistance plan under Code Section 129. Employee contributions to the Plan are made through the

Choices Plan, set forth in Chapter 5.33 of the Los Angeles County Code, the provisions of which are incorporated by reference into this Plan to the extent applicable. County contributions may be made as provided under the terms of this Plan.

5.34.020 Definitions.

A. "Annual Contribution Credits" means the total amount of Employer Contributions and Employee Contributions credited to a Covered Employee's Dependent Care Account for a Plan Year.

B. "Annual Enrollment" means the period before the start of each Plan Year during which Eligible Employees may elect to participate in the Cafeteria Plan and the programs offered thereunder, including this Plan, for that Plan Year.

C. "Board" means the Board of Supervisors of the County.

D. "Cafeteria Plan" means the Choices Plan established under Chapter 5.33 of the Los Angeles County Code.

E. "Claims Administrator" means the person or entity, if any, to whom the Plan Administrator delegates claims administration, including responsibility for:

1. receiving and reviewing claims for Plan benefits,

2. determining benefit amounts payable,

3. disbursing benefit payments,

4. reviewing denied claims, and

5. determining appeals, under the terms and conditions of a written agreement with the Plan Administrator.

F. "Code" means the Internal Revenue Code of 1986, as amended.

G. "County" means the County of Los Angeles.

H. "Coverage Period" means the period within each Plan Year during which a Covered Employee is covered for any incurred Qualifying Dependent Care Expenses. The Coverage Period for each Plan Year begins: (1) in the case of an Employee who becomes an Eligible Employee and enrolls pursuant to Section 5.34.030A.1 prior to Annual Enrollment, on the first day of the month following the date the Employee completes the enrollment process, and (2) following enrollment during an Annual Enrollment pursuant to Section 5.34.030A.2, the first day of the next following Plan Year, and continues for the remainder of the Plan Year; provided, however, that a Coverage Period does not include any period after which coverage has terminated or during which coverage is suspended in accordance with 5.34.030.

I. "Covered Employee" means an Eligible Employee who satisfies the enrollment, participation and coverage requirements of 5.34.030.

J. "Dependent Care Account" means the record-keeping account established by the Plan Administrator pursuant to Section 5.34.060B for each Eligible Employee who elects coverage under this Plan.

K. "Dependent Care Center" means a facility which provides care for more than six individuals (other than individuals who reside at the facility) and receives a fee, payment, or grant for providing services to any of the individuals.

L. "Earned Income" means wages, salaries, tips, other compensation, and net earnings from self-employment (as defined and limited by Code Section 32(c)(2)), but does not include amounts paid or incurred by an Employer for dependent care assistance to a Covered Employee. A spouse of a Covered Employee shall, for each month that spouse is a Full-Time Student or Incapable of Self-Care, be deemed to be gainfully employed and to have Earned Income of not less than $250 per month if the Covered Employee has one Qualifying Dependent and $500 per month if the Covered Employee has two or more Qualifying Dependents.

M. "Effective Date" of this Plan as amended and restated is January 1, 2008.

N. "Eligible Employee" means an Employee who is an eligible employee under the terms of the Cafeteria Plan and who works at least 8 hours or receives 8 hours of leave benefits in the prior calendar month.

O. "Employee" means any person who has been determined by an Employer (regardless of any determination made by any other person or entity) to be currently an employee of the Employer for federal income and/or employment tax purposes. The term Employee does not include any individual who has been classified by the Employer as an independent contractor or leased employee, except to the extent leased employees within the meaning of Code Section 414(n) must be taken into account in

applying nondiscrimination testing required under the Code. In the event that the Internal Revenue Service, another governmental agency with the authority to make a reclassification, or a court of competent jurisdiction, issues a final, binding decision that one or more individuals should be reclassified as employees for federal income and/or employment tax purposes, the Employer may change the status of such individuals to Employees, effective as of a date determined by the Employer following such decision.

P. "Employee Contribution" means a contribution made to the Plan in accordance with Section 5.34.040A.1.

Q. "Employer" means the County and (1) any governmental entity of which the Board is the governing body, (2) the Los Angeles County Superior Court to the extent participation is otherwise authorized by state law or rules of court, and (3) any related Employer which has adopted this Plan as a Participating Employer as described in Section 5.34.90.

R. "Employer" Contribution means a contribution made to the Plan in accordance with Section 5.34.040A.2.

S. "Full-Time Student" means an individual who during each of five calendar months of the Plan Year is a full-time student at an educational organization.

T. "Incapable of Self-Care" means that, due to physical or mental problems, an individual is incapable of caring for his hygienic or nutritional needs, or requires full-time attention of another person for his own safety or the safety of others.

U. "Maximum Annual Benefit" means, with respect to any Plan Year, the lesser of;

1. $4,800 ($2,500 for a married individual filing a separate federal income tax return),

2. the Covered Employee's Earned Income for the Plan Year, or

3. if the Covered Employee is married at the end of the Plan Year, the Earned Income of the Covered Employee's spouse for the Plan Year.

V. "Non-Represented Employees' Plan" means the County of Los Angeles Non-Represented Employees' Dependent Care Reimbursement Plan.

W. "Participating Employer" means an Employer which adopts this Plan in accordance with Section 5.34.90.

X. "Plan" means this Choices Dependent Care Reimbursement Plan, as amended from time to time.

Y. "Plan Administrator" means the person, entity, or committee appointed according to Section 5.34.070A, who is responsible for managing the Plan's operation and administration. If a Plan Administrator is not appointed, the County shall serve as Plan Administrator.

Z. "Plan Year" means the 12-month period beginning January 1 and ending December 31.

AA. "Qualifying Dependent" means any of the following who has the same principal place of abode as the Covered Employee for more than half of the calendar year:

1. a qualifying child (as defined in Code Section 152(c)) of the Covered Employee who is under the age of 13, and

2. a spouse or other dependent (as defined in Code Section 152, determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B)) of the Covered Employee who is Incapable of Self-Care. Notwithstanding the foregoing, if Code Section 152(e) applies to a child who is under age 13 or is Incapable of Self-Care, he shall be treated as a Qualifying Dependent of the Covered Employee if the Covered Employee is the custodial parent (as defined in Code Section 152(e)(4)(A)).

BB. "Qualifying Dependent Care Expenses" has the meaning set forth in Section 5.34.050.

CC. "Status Change" means:

1. a change in legal marital status, including marriage, death of spouse, divorce, legal separation, or annulment;

2. a change in the number of dependents, including birth, adoption, placement for adoption, or death of a dependent;

3. a change in the employment status of the Eligible Employee or the Eligible Employee's spouse, including an increase or decrease in the number of hours

of employment by the Eligible Employee or spouse, a change in worksite, a strike or lockout, or commencement or return from an unpaid leave of absence;

4. a dependent satisfying or ceasing to satisfy the requirements for being a Qualifying Dependent, unless the dependent's ceasing to satisfy such requirements is due solely to attainment of age 13; and

5. any other event the Plan Administrator determines permits revocation of an election under Code Section 125 and the regulations, rulings or other guidance issued thereunder.

5.34.030 Participation and coverage.

A. Enrollment.

1. Initial Enrollment. An individual who first becomes an Eligible Employee after the Effective Date but prior to an Annual Enrollment initially may participate in the Plan by completing the Cafeteria Plan enrollment process within the 60-day period beginning on the date the Employee becomes an Eligible Employee. Coverage for an Eligible Employee who enrolls in accordance with this Section shall be effective on the first day of the calendar month next following the date he completes the Cafeteria Plan enrollment process; provided, however, that an Eligible Employee who completes enrollment during November will not participate until the start of the next Plan Year. Except as provided in section 5.34.030A.3, if an Eligible Employee fails to enroll, he or she will not participate in the Plan for the remainder of the Plan Year.

2. Annual Enrollment. Prior to the beginning of each Plan Year, the Plan Administrator will conduct an Annual Enrollment, during which Eligible Employees may make new elections or change existing elections effective for the next following Plan Year. An Eligible Employee may become or continue to be a Covered Employee under this Plan by completing the Annual Enrollment process by the end of the Annual Enrollment period established by the Plan Administrator. Coverage elected under this Plan during an Annual Enrollment shall be effective as of the first day of the Plan Year following the Annual Enrollment. If an Eligible Employee fails to enroll, he or she will not participate in the Plan for the next following Plan year.

3. Change in Employment Classification During Plan Year.

a. If a participant in the Options Dependent Care Reimbursement Plan or the Non-Represented Employees' Plan for a Plan Year ceases to be eligible thereunder but becomes an Eligible Employee under this Plan during that Plan Year, he will have the opportunity to enroll in this Plan under Section 5.34.030A.1, provided, however, that his coverage under this Plan will not become effective until the first day of the second month following the date he completes the enrollment process. If he fails to complete the enrollment process within the 60-day period described in Section 5.34.030A.1, he will automatically become a Covered Employee under this Plan effective as of the first day of the second month after the 60-day enrollment period ends, and his election regarding the level of his employee contributions under the Options

Dependent Care Reimbursement Plan or Non-Represented Employees' Plan will continue in effect under this Plan for the remainder of the Plan Year.

b. If a Covered Employee ceases to be a Covered Employee and becomes eligible to participate in the Options Dependent Care Reimbursement Plan or Non-Represented Employees' Plan during a Plan Year, he will have a 60-day period in which to complete the enrollment process for that plan; provided, however that his coverage under the Options Dependent Care Reimbursement Plan or Non-Represented Employees' Plan will not become effective until the first day of the second month following the date he completes the enrollment process. If he fails to complete the enrollment process within the 60-day period, he will automatically begin participating in the Options Dependent Care Reimbursement Plan or Non-Represented Employees' Plan, as applicable, effective as of the first day of the second month after the 60-day enrollment period, and his election regarding the level of Employee Contributions under this Plan will continue in effect under the Options Dependent Care Reimbursement Plan or Non-Represented Employees' Plan, as applicable, for the remainder of the Plan Year.

4. Enrollment Information and Deadlines. In order to complete the enrollment process during initial enrollment or Annual Enrollment as described in this Section 5.34.030, an Eligible Employee shall specify the amount of Employee Contributions, if any, to be credited to his Dependent Care Account and the corresponding Annual Contribution Credits for the Plan Year, and shall provide any

other information required by the Plan Administrator. The form and content of any enrollment materials, and any limitations with respect to the time for completing the enrollment process, shall be determined by the Plan Administrator and communicated to Eligible Employees prior to enrollment.

5. Limits. The maximum Annual Contribution Credits that may be elected under the Plan for any Plan Year is the Maximum Annual Benefit as defined in Section 5.34.020U. The amount that may be excluded from the gross income of a Covered Employee and his spouse, if any, with regard to Qualifying Dependent Care Expenses reimbursed under this Plan or any other dependent care reimbursement plan in any calendar year shall be limited in accordance with Code Section 129.

B. Coverage.

1. Initial Coverage. An Eligible Employee may become a Covered Employee during a Plan Year as of the first day of the calendar month next following the date he completes the Cafeteria Plan enrollment process in accordance with Section 5.34.030A.1. Except as otherwise provided in this Section 5.34.030, coverage shall remain effective for the balance of the Plan Year.

2. Annual Enrollment. Prior to the beginning of each Plan Year, the Plan Administrator will conduct an Annual Enrollment, during which Eligible Employees may make new elections or change existing elections effective as of the first day of the

next following Plan Year. Except as otherwise provided in this Section 5.34.030, benefit elections shall remain effective for the entire Plan Year.

3. Change in Employment Classification During Plan Year. An Eligible Employee who enrolls or is defaulted into coverage in accordance with Section 5.34.030A.3.a shall become a Covered Employee as of the first day of the second calendar month after either (a) the date he completes enrollment or, (b) if he is defaulted into the Plan, the end of the 60-day enrollment period. Except as otherwise provided in this Section 5.34.030, coverage shall remain effective for the balance of the Plan Year.

4. Coverage During Leave of Absence or When Not Receiving Pay. A Covered Employee's coverage under the Plan shall continue while he is on a paid or unpaid leave of absence even if no Employer Contributions or Employee Contributions are credited to his Dependent Care Account during that period; provided, however, that the Covered Employee's Annual Contribution Credits will be reduced to reflect any Employee Contributions and Employer Contributions that are not made during that period.

C. Termination of Coverage.

1. Date Coverage Ceases. Plan coverage ceases upon the earliest to occur of:

a. the first day of the second month immediately following the date the Covered Employee ceases to be an Employee or an Eligible Employee, unless

the Covered Employee has changed employment classification and plan participation during the Plan Year as described in Section 5.34.030A.3.b;

b. in the case of a Covered Employee who changes employment classification and plan participation during the Plan Year as described in Section 5.34.030A.3.b., the first day of the second month following the earlier of (1) the date he completes the enrollment process under the Options Dependent Care Reimbursement Plan or Non-Represented Employees' Plan, or (2) the end of the 60-day enrollment period;

c. the effective date of the Covered Employee's election not to participate, or failure to elect to participate, in the Plan under Section 5.34.030A.1 or 2;

d. the effective date of any Plan amendment that terminates coverage for the Covered Employee's job category; or

e. the date of Plan termination.

2. Effect of Termination of Coverage. No benefits are payable for Qualifying Dependent Care Expenses incurred after Plan coverage terminates (and before the date, if any, that it is reinstated).

D. Revoking and Changing Elections.

1. General Rule. Except in extraordinary circumstances described in this subsection D, benefit elections shall be irrevocable for the Plan Year for which they are made. Any new benefit election made under this subsection D must be made within

90 days beginning on the date of the event that is the reason for the new election. Any new benefit election shall be effective on the first day of the month following the correct and timely completion and submission of all required forms. This subsection D shall be interpreted and applied in accordance with applicable Treasury regulations and in a nondiscriminatory manner in accordance with Code Sections 125 and 129.

2. Revocation of Elections for Status Change; Consistency Rule.

a. General Rule. The Plan Administrator may, in its discretion, permit (i) a Covered Employee to revoke a benefit election under the Plan and make a new benefit election or (ii) an Eligible Employee who is not participating in the Plan to make a benefit election and commence participation in the Plan, if a Status Change occurs and the election change or new election satisfies the consistency requirements described in subparagraph 2.b below.

b. Consistency Rules. An election change or new election satisfies the requirements of this paragraph if the election change or new election is on account of and corresponds with a Status Change that affects (i) eligibility for coverage under an employer's dependent care reimbursement account plan, or (ii) expenses described in Code Section 129.

3. Cost Changes.

a. Significant Cost Changes. If the cost of a Covered Employee's Qualifying Dependent Care Expenses significantly increases or significantly decreases during a Plan Year, or if the cost to the Covered Employee (e.g., the

necessary level of Employee Contributions) to maintain the elected Annual Contribution Credits for the Plan Year increases due to the reduction or termination of Employer Contributions under Section 5.34.040A.2, the Plan Administrator, in its discretion, may permit any affected Covered Employee to revoke his existing election and make a new election to reflect the increased or decreased cost.

b. Limitation. Notwithstanding anything to the contrary in this Section 5.34.030D.3, no election changes under the Plan shall be permitted as a result of a change in cost for Qualifying Dependent Care Expenses imposed by a dependent care provider unless such change in cost is imposed by a dependent care provider who is not a qualifying relative (as defined in Code Section 152(d)) of the Covered Employee.

4. Significant Improvement or Curtailment of Coverage (Services). If the dependent care services being provided to a Covered Employee are significantly improved or curtailed (e.g., if the entity or person providing dependent care services changes or if the hours of services provided change), the Plan Administrator, in its discretion, may permit the Covered Employee to revoke his existing election and make a new election to reflect the cost of the modified services.

5. Change in Coverage Under Another Employer Plan. The Plan Administrator may permit a Covered Employee to prospectively change or revoke an existing benefit election under the Plan if the election change is on account of and corresponds with a change made under another Employer plan (including a plan of the

same Employer or of another Employer) that would be permitted under this Section (without regard to this subsection 5). The Plan Administrator also may permit a Covered Employee to make a prospective election to drop coverage under the Plan if dropping such coverage is on account of and consistent with adding coverage under another Employer's plan provided that the period of coverage or plan year under the plan does not correspond with the period of coverage or Plan Year under this Plan.

5.34.040 Contributions and funding.

A. Contributions.

1. Employee Contributions. During enrollment in accordance with Section 5.34.030, and pursuant to the terms of the Cafeteria Plan, an Employee may elect to have his Employer credit a portion of his Contribution (as defined in the Cafeteria Plan) to his Dependent Care Account. The amount elected may not be less than $10 or more than the amount that, together with any monthly Employer Contribution, would cause his Annual Contribution Credits to exceed the Maximum Annual Benefit. To the extent permitted under Code Sections 125 and 129, Employee Contributions will be treated like non-taxable Employer contributions.

2. Employer Contributions. Each Employer may contribute up to a designated dollar amount per month to the Plan on behalf of each Covered Employee employed by that Employer who elects to receive an Employer Contribution. Subject to negotiation with the certified bargaining organizations that represent an Employer's Eligible Employees, the Employer shall establish the maximum amount of the monthly

Employer Contribution that it will make on behalf of each Covered Employee, as well as any annual cap on total Employer Contributions, for each Plan Year. The Plan Administrator shall disclose to Eligible Employees prior to enrollment the maximum level of Employer Contribution that may be made on behalf of each Covered Employee and the existence of the cap. A Covered Employee does not need to make Employee Contributions to receive an Employer Contribution. An Eligible Employee who does not enroll in the Plan will not be entitled to an Employer Contribution.

In the event an Employer establishes an annual cap on Employer Contributions on behalf of Covered Employees, the Employer may, without prior notice to Covered Employees and at any time during the Plan Year, reduce or terminate the Employer Contribution to be made for some or all Covered Employees in any manner consistent with Code Section 129(d) and the terms negotiated with the Eligible Employees' bargaining unit representative(s) to prevent the cap from being exceeded. The Plan Administrator shall notify affected Covered Employees if their Employer Contributions will be reduced or terminated and their Annual Contribution Credits reduced due to imposition of a cap.

3. Termination or Suspension of Contributions. An Employer will not make an Employer Contribution or Employee Contribution for a month on behalf of a Covered Employee if he works less than 8 hours or receives less than 8 hours of leave benefits in the prior month. An Employer also will not make an Employer Contribution or Employee Contribution on and after the first day of the second month after the

Covered Employee ceases to be an Employee or an Eligible Employee unless the Covered Employee changes employment classifications and plan participation as described in Section 5.34.030A.3.a. If the Covered Employee changes employment classifications and plan participation as described in Section 5.34.030A.3.a, he will not receive an Employer Contribution or Employee Contribution on or after the date his coverage under the Plan terminates in accordance with Section 5.34.030C.1.b.

B. Plan Funding. The Plan is not required to be and is not funded or insured. Benefits paid to a Covered Employee are paid solely out of the general assets of the Employee's Employer.

5.34.050 Dependent care expense reimbursement benefit.

A. Reimbursement of Qualifying Dependent Care. Subject to the terms and limits set forth in this Section 5.34.050, Covered Employees may be reimbursed for Qualifying Dependent Care Expenses as defined in Section 5.34.050B.

B. Qualifying Dependent Care Expenses Defined. Qualifying Dependent Care Expenses means expenses incurred by the Covered Employee for household services or for the care of a Qualifying Dependent but only if such expenses are incurred to enable the Covered Employee (and the Covered Employee's spouse, if any) to be gainfully employed or to search for gainful employment for any period for which there are one or more Qualifying Dependents with respect to the Covered Employee, and subject to the exclusions set forth in Section 5.34.050C. For these purposes:

1. A Covered Employee's spouse is deemed gainfully employed for each month that he is a Full-Time Student or is Incapable of Self-Care.

2. Volunteer work for a nominal salary does not constitute gainful employment.

3. Expenses paid for a period during only part of which a Covered Employee or spouse is gainfully employed or in active search of gainful employment must be allocated on a daily basis, unless such expenses are incurred during a short, temporary absence from work (such as for vacation or minor illness) and the dependent care arrangement requires payment for care during the absence. An absence of two consecutive calendar weeks is deemed a short, temporary absence.

4. Expenses are for the care of a Qualifying Dependent only if their primary purpose is to assure the individual's well-being and protection. Expenses incurred for the care of a Qualifying Dependent may include employment taxes on the wages of a care provider, the additional costs of room and board for a care provider over usual household expenditures, and expenses that relate to, but are not directly for, the care of a Qualifying Dependent such as application fees, agency fees and deposits if the Covered Employee is required to pay those expenses to obtain the related care. Forfeited deposits or other payments are not for the care of a Qualifying Dependent if care is not provided in connection with those amounts.

5. Expenses are paid for household services if they are paid for the performance in and about the Covered Employee's home of ordinary and usual services

necessary to the maintenance of the household, provided the expenses are attributable to the care of a Qualifying Dependent. Services of a housekeeper are household services if the services are provided, at least in part, to the Qualifying Dependent.

6. Expenses that are incurred for services outside the Covered Employee's household may qualify as Qualifying Dependent Care Expenses only if such expenses are incurred for the care of a Qualifying Dependent described in subsection 5.34.020AA.1 of this Plan or any other Qualifying Dependent who regularly spends at least 8 hours each day in the Covered Employee's household.

7. Expenses that are incurred for services provided outside the Covered Employee's household by a Dependent Care Center may qualify as Qualifying Dependent Care Expenses only if such center complies with all applicable state and local laws and regulations applicable to such facility.

8. The cost of transportation by a care provider of a Qualifying Dependent to or from a place where care of the Qualifying Dependent is provided may be for the care of the Qualifying Dependent.

9. Qualifying Dependent Care Expenses are incurred on the date the dependent care is provided, not on the date charged, billed, or paid.

C. Exclusions. Notwithstanding any other provision of this Plan to the contrary, Qualifying Dependent Care Expenses do NOT include:

1. Any amounts paid for services outside the Covered Employee's household at a camp where the Qualifying Dependent stays overnight.

2. Expenses incurred in connection with services rendered by: (a) a Covered Employee's child or a child of the Covered Employee's spouse who is under the age of 19 as of the end of the Plan Year, or (b) a person who qualifies as a dependent of the Covered Employee or a dependent of the Covered Employee's spouse and for whom a deduction is allowable under Code Section 151(c) to the Covered Employee or to the Covered Employee's spouse for the Plan Year.

3. The costs of a Qualifying Dependent's food, clothing, entertainment, or education (unless for a child below kindergarten) unless those costs are incidental, minimal, and inseparable from the cost of caring for a Qualifying Dependent.

4. The costs of transportation other than as provided in subsection 5.34.050B.8.

D. Coverage Period Limitations. Qualifying Dependent Care Expenses reimbursed by the Plan for a Plan Year must have been incurred during the Coverage Period. Accordingly, with regard to each Plan Year, the Plan will not reimburse any expenses incurred:

1. before the start of the Plan Year or after the end of the Plan Year,

2. before a benefit election becomes effective in accordance with Section 5.34.030, or

3. after coverage terminates or during a period in which coverage is suspended in accordance with Section 5.34.030.

E. Amount Payable. Reimbursement of Qualifying Dependent Care Expenses may not exceed the Annual Contribution Credits elected for the Plan Year, or the balance credited to a Covered Employee's Dependent Care Account at the time such reimbursement is made. Any unused balance in a Covered Employee's Dependent Care Account after the claims period described in Section 5.34.060C has expired shall be forfeited.

F. Code Limitations on Benefits. Benefits payable under the Plan to each highly compensated Employee, as defined in Code Section 414(q), are limited to the extent necessary to avoid violating the nondiscrimination requirements contained in Code Section 129.

5.34.060 Procedures.

A. Enrollment and Election Procedures. Eligible Employees may enroll, specify the amount of his Employee Contributions and designate the corresponding Annual Contribution Credits for a Plan Year only by completing the enrollment procedure in accordance with Section 5.34.030. Upon initial eligibility and during Annual Enrollment, the Plan Administrator will provide all Eligible Employees with

information about permissible benefit elections under the Plan and procedures for enrollment and benefit elections.

B. Dependent Care Accounts. The Plan Administrator shall establish a Dependent Care Account for each Covered Employee. Each Covered Employee's Dependent Care Account will be credited with Employee Contributions and/or Employer Contributions in accordance with Section 5.34.040, and will be debited by the amount of any Qualifying Dependent Care Expenses paid or incurred on behalf of the Covered Employee under the Plan for the Plan Year. The amount of Qualifying Dependent Care Expenses payable from the Plan at any time shall be limited pursuant to Section 5.34.050E of the Plan. Any unused balance in a Covered Employee's Dependent Care Account after the claims period described in Section 5.34.060C has expired for any Plan Year shall be forfeited.

C. Claim Procedures. Any Covered Employee (or duly authorized representative) seeking Plan benefits shall assert a claim under the procedures of this Section regardless of the basis asserted for the claim or when the act or omission occurred on which the claim was based. The Plan Administrator or Claims Administrator will provide, upon request, forms required for filing a claim for Plan benefits and instructions on the information that must be submitted for the claim to be processed. The Plan Administrator shall determine the information that must be included in any claim submission. Such information may include, but is not limited to:

1. itemized bills or receipts,

2. the amount, date, and nature of the expense,

3. the name, address, social security number or tax identification number and signature of the provider,

4. the name of the person for whom the expense was incurred and the person's relationship to the Covered Employee,

5. the amount, if any, that has been reimbursed or is reimbursable from any other source, and

6. any other information required by the Plan Administrator.

Claimants must complete and file the appropriate forms with the Claims Administrator by June 30th following the close of the Plan Year to which the claim relates.

D. Claim Determination. The Plan Administrator or Claims Administrator shall determine all matters pertaining to claims for Plan benefits. If the Plan Administrator or Claims Administrator denies a Covered Employee's claim for benefits, the entity reviewing such claim shall notify the Covered Employee in writing of such denial within a reasonable period of time.

E. Claim Review Procedures.

1. Appeal Process. A Covered Employee may appeal an adverse benefit determination under the Plan to the Plan Administrator by filing an appeal to the Plan Administrator within 180 days of receiving notice of the adverse benefit determination. If the Plan Administrator upholds the adverse benefit determination on

appeal, it shall provide written notification to the Covered Employee of such determination as soon as reasonably possible.

2. Determination Final. The Plan Administrator's decision on appeal shall be final and binding on all persons.

5.34.070 Plan administration.

A. Plan Administrator. The County of Los Angeles shall act as Plan Administrator except to the extent that it delegates its responsibilities in accordance with Section 5.34.070.

B. Plan Administrator's Duties. The Plan Administrator's duties include:

1. Management of Plan operations and administration according to the Plan's terms and for the exclusive benefit of Covered Employees;

2. Maintenance of:

a. records and data necessary or desirable for the Plan's proper operation and administration; and

b. governing documentation of the Plan for inspection by any Covered Employee under the Plan;

3. Notification of Eligible Employees of the Plan's availability and terms; and

4. Preparation and filing of all annual reports or returns, Plan descriptions, financial statements, and other documents required by law or under the Plan's terms.

C. Plan Administrator's Powers. The Plan Administrator may exercise, in a uniform and nondiscriminatory manner, sole and absolute discretion in the Plan's operation and administration, including:

1. Establishment of such rules and regulations not inconsistent with the terms of the Plan as it deems necessary or proper for the efficient administration of the Plan and for the payment of benefits under the Plan;

2. Interpretation of the Plan, making decisions regarding all questions of the eligibility of persons to participate in the Plan and making factual determinations under the Plan, construction of any ambiguous provision of the Plan, correction of any defect, supplying any omission, or reconciliation of any inconsistency, in such manner and to such extent as the Plan Administrator in its discretion may determine, and any such action of the Plan Administrator will be binding and conclusive upon all Covered Employees;

3. Appointment of such agents, counsel, accountants, consultants, and other persons as may be required to assist in administering the Plan, including, without limitation, Employees of an Employer or a third-party Claims Administrator; and

4. Allocation and delegation of responsibilities under the Plan and designation of such departments, Employees, committees, entities, or persons

including, without limitation, a third-party administrator (such as a third-party Claims Administrator), to carry out any of its responsibilities under the Plan.

D. Plan Administrator Determinations and Actions. The Plan Administrator shall use ordinary care and diligence in performing its duties.

1. Expenses and Compensation. Unless the County agrees otherwise, the Plan Administrator shall serve without compensation. The County shall pay all reasonable expenses the Plan Administrator incurs in performing its duties.

2. Indemnification. The County shall indemnify and hold harmless any Employee who serves or served as Plan Administrator from all claims, liability, and costs (including reasonable attorneys' fees) arising out of being the Plan Administrator or performing the Plan Administrator's duties, except if the claim, liability, or cost is the result of such individual's willful misconduct or bad faith.

5.34.080 Plan amendment or termination.

A. Permanence of the Plan. The Plan shall continue in full force and effect unless amended or terminated by the County as provided in Section 5.34.080B hereto.

B. Plan Amendment or Termination. The County reserves the right to amend or terminate the Plan at any time; provided, however, that the termination of the Plan or the amendment of any provisions subject to negotiation under applicable law shall be negotiated with the affected certified bargaining organizations.

C. Effect of Amendment or Termination; No Vested Rights. No amendment or termination of the Plan shall have any retroactive effect so as to deprive any Covered Employee of any benefit then payable. Notwithstanding the foregoing, any amendment or termination of the Plan may be made retroactive to the extent necessary for the Plan to comply with any applicable law. No Covered Employee has any vested right to continue to receive benefits under the Plan.

5.34.090 Miscellaneous provisions.

A. No Employment Rights. Nothing contained in the Plan shall be construed as a contract of employment between an Employer and any Employee, or as the right of any Employee to continue in the employment of an Employer, to be employed for any specific period of time.

B. Exclusive Obligations and Rights. The County, an Employer, and the Plan Administrator do not have any obligation or duty other than as stated in the Plan and, except as specified in this document, no one has a right to Plan benefits or a legal or equitable right against the County, the Board, an Employer, the Plan, or the Plan Administrator.

C. No Assignment of Benefits. Except to the extent required in accordance with applicable law, Plan benefits are not subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, levy or charge of any kind, and any attempt to effect any of these actions is void.

D. Misrepresentation or Fraud. A Covered Employee who receives a Plan benefit as a result of false or incomplete information or a misleading or fraudulent representation shall repay all amounts the Plan paid and is liable for all collection costs including attorneys' fees and court costs.

E. Legal Action.

1. Exhaustion of Administrative Procedures. Before pursuing legal action, a person claiming Plan benefits or seeking redress related to the Plan shall first exhaust all claim, review and appeal procedures provided by the Plan. No action at law or in equity may be brought to recover Plan benefits or seek redress related to the Plan until the claim procedures contained in Section 5.34.060 have been exhausted.

2. Necessary Parties. Unless otherwise required by law, the County and the Plan Administrator are the only necessary parties to any action or proceeding that involves the Plan or its administration. No Employee, Employer or other person or entity is entitled to notice of any legal action, unless a court with appropriate jurisdiction orders otherwise.

F. Governing Law. The Plan's provisions and all Plan matters, including actions of the parties involved, are construed and enforced according to applicable California laws unless preempted by federal law.

G. Governing Instrument. This writing, together with any documentation incorporated by reference, is the legal instrument governing the Plan. In case of conflict between this document and any of the writings incorporated by reference, the provisions

of the documentation govern in the following order: this document, any other plan document, any summary plan description, any enrollment or election form, and, finally, any other writing; provided, however, that in the event of a conflict between this document and an applicable memorandum of understanding with a certified bargaining organization representing Eligible Employees, the conflict shall be resolved in accordance with County Code section 6.28.140. Except as provided in this subsection 5.34.090G., no writing or evidence may contradict or interpret the Plan's terms or provisions unless specifically incorporated by reference herein.

H. Savings Clause. If a Plan provision or its application is held invalid under governing law by a court of appropriate jurisdiction, the remainder of the Plan and its application will not be affected.

I. Parties' Liability. Neither the County, the Board, an Employer, the Plan Administrator, nor any delegate thereof, shall be liable for:

1. good faith reliance on any fact or absence of fact, good faith action, or good faith omission,

2. another person's act or omission, unless required by law, or

3. the tax consequences of contributions to or benefits paid from the Plan.

J. Tax Consequences Not Guaranteed. Neither the County, the Board, an Employer, the Plan, the Plan Administrator, nor any other person connected with any

such person or entity guarantees that Plan benefits are or will be excludable from a Covered Employee's gross income for federal, state, or local income tax purposes, or that any other tax treatment is or will be applicable or available. Covered Employees themselves shall determine whether Plan benefits are excludable for these purposes, and shall notify the Plan Administrator if they have reason to believe a payment is not excludable. If the Plan Administrator determines at any time after the end of a Plan Year that contributions to the Plan or benefits paid exceeded limits allowed by law for any reason including, but not limited to, erroneous information, administrative error or failure to satisfy prohibitions on discrimination, then affected Covered Employees shall:

1. pay any local, state, and federal income taxes and related penalties and interest due with respect to the excess contributions or benefits, and

2. reimburse the Employer for the Employee's share of any local, state, and federal tax contributions the Employer would have withheld or other applicable deductions the Employer would have taken had the excess contributions or benefits been treated as taxable income.

K. Nondiscrimination. If, in the judgment of the Plan Administrator, the Plan may fail to meet the requirements of Section 129(d) of the Code, the Plan Administrator will take such action as it deems appropriate to assure compliance with such requirements. The action taken by the Plan Administrator may include, without limitation, a modification of the elections of certain Covered Employees who are defined

as "highly compensated employees" under Code Section 414(q). Such action may be taken by the Plan Administrator without consent of the affected Covered Employee.

L. Participating Employers. With the County's consent, an Employer may adopt or withdraw from this Plan.

Each Participating Employer shall file with the Plan Administrator a notice of adoption specifying:

1. the effective date of its adoption, and

2. any other information the Plan Administrator may require to carry out its duties under the Plan. Except for functions reserved to the County, the Plan Administrator has exclusive authority over all Plan matters and acts as agent of all Employers that have at any time adopted the Plan.

An adopting Employer may withdraw from Plan participation by giving the County and the Plan Administrator 60 days advance written notice of its withdrawal. Similarly, the County may terminate an Employer's Plan participation by giving the Employer and Plan Administrator 60 days advance written notice of the termination. Upon an Employer's withdrawal or termination of participation, the Plan Administrator must provide the Employer with copies of all records that the Plan Administrator determines necessary for the Employer to terminate and administer its portion of the Plan. An Employer's withdrawal or termination of Plan participation operates only as to that Employer's Employees.

SECTION 14. Section 5.36.080 is hereby amended to read as follows:

5.36.080 Contributions to indemnity dental insurance coverage.

A. For employees enrolled in the County sponsored Delta Dental Plan, or any successor County sponsored indemnity dental plan, the County shall provide a monthly subsidy toward the cost of such coverage for each employee and each employee' s covered family members, as set forth in Table A, Table B, or Table C below.

TABLE A

Monthly Employer Contribution Rates Applicable to Participants in the Local 721 Cafeteria Program Established Under Chapter 5.37

	Effective	**Effective**	**Effective**
Coverage	**1-1-07**	**1-1-08**	**1-1-09**
Employee only	$20.59	$20.59	$20.59
Employee plus one dependent	36.02	36.02	36.02
Employee plus two or more dependents	56.58	56.58	56.58

TABLE B

Monthly Employer Contribution Rates Applicable to Participants in the Choices Plan Established Under Chapter 5.33

Coverage	**Effective ~~1-1-04~~ 1-1-07**	**Effective ~~1-1-05~~ 1-1-08**	**Effective ~~1-1-06~~ 1-1-09**
Employee only	~~$14.37~~	~~$17.48~~	~~$20.59~~
	$20.59	$20.59	$20.59
Employee plus one dependent	~~25.98~~	~~31.00~~	~~36.02~~
	36.02	36.02	36.02
Employee plus two or more dependents	~~40.77~~	~~48.60~~	~~56.58~~
	56.58	56.58	56.58

TABLE C

Monthly Employer Contribution Rates Applicable to Participants in the Pensionable or Nonpensionable Flexible Benefit Plans Established Under Chapters 5.27 and 5.28, Respectively

Coverage	Effective 1-1-07	Effective 1-1-08	Effective 1-1-09
Employee only	$21.11	$21.11	$21.11
Employee plus child(ren)	47.84	47.84	47.84
Employee plus adult dependent	40.53	40.53	40.53
Employee plus adult dependent and child(ren)	61.32	61.32	61.32

...

SECTION 15. Section 5.37.020 is hereby amended to read as follows:

5.37.020 Definitions.

The following terms when used herein with initial capital letters, unless the context clearly indicates otherwise, shall have the following respective meanings:

A. "Benefit" means cash and/or one or more Nontaxable Benefits or Taxable Benefits.

B. "Board" means the Los Angeles County board of supervisors.

C. "~~CAO~~ CEO" means the chief ~~administrative~~ executive officer of the County appointed by the Board pursuant to the Los Angeles County Code.

D. "Code" means the Internal Revenue Code of 1986, as amended.

E. "Contribution" means any Nonelective Contribution or Elective Contribution made on behalf of a Participant pursuant to Section 5.37.040.

F. "County" means the County of Los Angeles and (1) any governmental entity of which the Board is the governing body; and (2) the Los Angeles County Municipal Courts and the Los Angeles County Superior Court to the extent the operation of this Plan in said courts is otherwise authorized by state law or rules of court.

G. "Dental Insurance Plan" means any of the dental insurance plans included in the Materials definition set out in subsection P of this section.

~~H. "Dependent Care Expenses" means any "employment-related expenses" as defined in Section 44A(c)(2) of the Code incurred during a Plan Year by a Participant.~~

~~I.~~ H. "Dependent Care Spending Account" means an individual account established and maintained for a Participant to which Contributions are periodically credited and benefits periodically paid pursuant to Chapter 5.41 ~~Section 5.37.060 F of this chapter and from which Dependent Care Expenses are paid~~.

~~J.~~ I. "Domestic Partner" means a qualified person pursuant to the provisions of Chapter 2.210 of the Los Angeles County Code.

~~K.~~ J. "Effective Date" means July 1, 1992, except that for Eligible Employees in Registered Nurses Representation Unit (Unit 311) and Supervisory Registered Nurses Representation Unit (Unit 312) the Effective Date shall mean April 1, 1992.

~~L.~~ K. "Elective Contribution" means the amount allocated to specific Taxable Benefits and/or Nontaxable Benefits at the election of a Participant equal to a reduction in his Eligible Earnings pursuant to Section 5.37.040 B.

~~M.~~ L. "Eligible Earnings" means any compensation paid to an Eligible Employee for service performed for the County which is currently includable in gross income under the Code.

~~N.~~ M. "Eligible Employee" means a full-time permanent employee of the County who is not in an Excluded Bargaining Unit and who is designated by the Board as eligible to participate in the Plan. For purposes hereof, "full-time permanent" means any employee appointed to an "A," "M" or "N" item pursuant to Title 6 of the Los Angeles County Code, or any employee appointed to a "D" item pursuant to said Title 6 who is required to possess a California license to practice as a Registered Nurse.

~~O.~~ N. "Excluded Bargaining Unit" means an employee representation unit, for which there is no agreement between the representatives of the unit and the County as to the extension of the Plan to the employees of the unit.

~~P.~~ O. "Materials" means the booklets, manuals, handbooks, contracts, plan documents or sections thereof, and other provisions of the Los Angeles County Code relating to the County-sponsored or County-approved union-sponsored health and welfare plans listed below, as the same may be amended or restated from time to time:

1. Kaiser Foundation Health Plan, Inc.;
2. PacifiCare Health Plan;
3. Delta Dental Plan;

4. DELTACARE;

5. Safeguard Health Plans, Inc. Dental Plan;

6. Life insurance provided by the CIGNA Employee Benefits Companies exclusive of any life insurance provided under Section 5.36.070 or 5.36.075 of the Los Angeles County Code;

7. Accidental death and dismemberment insurance provided by the CIGNA Employee Benefits Companies;

8. The Local 660 Health Care Spending Account;

9. The Local 660 Dependent Care Spending Account;

10. LTD Health Insurance provided under subsection H of Section 5.38.020 of the Los Angeles County Code.

~~Q.~~ P. "Medical Insurance Plan" means any of the medical insurance plans included in the Materials definition set out in subsection ~~P~~ O of this section.

~~R. "Maximum Amount" means the Contribution amount selected by a Participant (on an election form furnished by the County) for credit to his Dependent Care Spending Account; provided, however, that such amount shall not exceed the lesser of $400.00 per month or the "earned income" (as defined in Section 43(c)(2) of the Code) of the Participant, or, if the Participant is married, of either the participant or his spouse.~~

~~S.~~ Q. "Medical Care" means amounts paid (1) for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body; or (2) for transportation primarily for and essential to medical care

referred to in S(1) above; or (3) for insurance covering medical care referred to in S(1) and (2) above. This definition is to be construed in accordance with Section 213(d)(1) of the Code.

~~T.~~ R. "Medical Expenses" means all expenses incurred during a plan year by a Participant for the Medical Care of himself, his spouse and his dependents (as defined in Section 152 of the Code), irrespective of whether such expenses were incurred in connection with such Participant' s employment.

~~U.~~ S. "Nonelective Contribution" means the amount available for allocation to particular Taxable Benefits and/or Nontaxable Benefits or for receipt as additional Eligible Earnings by a Participant pursuant to Section 5.37.040 A.

~~V.~~ T. "One Party Medical Insurance Coverage" means medical insurance coverage for a Participant only. Such coverage must be provided through the Plan by a Medical Insurance Plan.

~~W.~~ U. "Nontaxable Benefit" means participation in any health or welfare program sponsored by the County, or sponsored by an employee union and approved by the County, insured or uninsured, now existing or hereafter adopted, described in the Materials definition, the cost of which is excludable from the gross income of the Participant pursuant to Section 79, 105, 106, or 129 of the Code or any other applicable Code section as the same may be amended.

~~X.~~ V. "Participant" means any Eligible Employee or former Eligible Employee who meets the requirements for participation in the Plan set forth in Sections 5.37.030 and 5.37.050.

~~Y.~~ W. "Plan" means the Local 660 Cafeteria Plan, as the same may be amended or restated from time to time.

~~Z.~~ X. "Plan Year" means the period July 1, 1992 through December 31, 1992, excepting for Registered Nurses Representation Unit (Unit 311) and Supervisory Registered Nurses Representation Unit (Unit 312) for which Plan Year shall mean April 1, 1992 through December 31, 1992; provided, however, that with respect to all periods subsequent to December 31, 1992, Plan Year shall mean the calendar year.

~~AA.~~ Y. "Taxable Benefit" means participation in certain health or welfare programs provided or sponsored by the County, insured or uninsured, now existing or hereafter adopted, described in the Materials definition, the cost of which will be treated by the County as includable in the gross income of the Participant pursuant to the Code as the same may be amended.

~~BB.~~ Z. "Two-Party Medical Insurance Coverage" means medical insurance coverage for a Participant and one of his dependents. Such coverage must be provided through the Plan by a Medical Insurance Plan.

~~CC.~~AA. "Three-Party Medical Insurance Coverage" means medical insurance coverage for a Participant and two or more of his dependents. Such coverage must be provided through the Plan by a Medical Insurance Plan.

SECTION 16. Section 5.38.010 of the Long Term Disability and Survivor Benefit Plan is hereby deleted in its entirety.

SECTION 17. Section 5.38.010 is added to read as follows:

5.38.010 Definitions.

A. "Applicable Health Insurance Coverage" means coverage under a County-sponsored medical plan offered through the Cafeteria Plan for which an employee, Medical Dependent or LTD Health Survivor would be eligible if the employee were not disabled or deceased.

B. "Basic monthly compensation" means the average monthly base rate, as established in Title 6 of this Code, as amended, on salaries, hereinafter referred to as "Title 6," for the position or positions the employee held during the 12 consecutive months immediately preceding the qualifying period; provided, however, that in no event shall the basic monthly compensation include the following:

1. Overtime compensation; or

2. Any lump-sum payoff or reimbursement for unused accumulated overtime, vacation, holiday time, or sick leave benefits; or

3. Compensation from two or more positions held on a concurrent basis. In any case in which the base rate is established in Title 6 on other than a monthly basis, the equivalent monthly base rate provided for in Chapter 6.15 of Title 6 shall be deemed to be the monthly base rate for purposes of this section.

C. "Cafeteria Plan" means either the pensionable or nonpensionable Flexible Benefit Plan set forth in subdivision 1 of Chapter 5.27 or 5.28 of this Code, The Choices

Plan set forth in Chapter 5.33 of this Code, or The Local 660 Cafeteria Plan set forth in Chapter 5.37 of this Code, as applicable.

D. "Covered Employee" means an employee who is (1) an "Eligible Employee" or a "Participant" under the terms of an applicable Cafeteria Plan, and (2) enrolled in a County-sponsored medical plan.

E. "Disability beneficiary" means a former employee who has not retired from service under Retirement Plan E, and who either is receiving disability benefits or is eligible to receive disability benefits.

F. "Eligible employee" means an employee who becomes totally disabled:

1. As a direct consequence and result of injury or disease arising out of and in the course of the performance of his or her assigned duties; or

2. After five years of continuous service with the county.

G. "Employee" means an employee of the county of Los Angeles who is a general member of the Los Angeles County Employees Retirement Association. General member does not include a safety member.

H. "LTD Health Insurance Benefit" means a benefit that pays for 75 percent or 100 percent of the cost of Applicable Health Insurance Coverage at the time such coverage is provided pursuant to the rules in section 5.38.020H.,

I. "LTD Health Survivor" means a spouse, domestic partner as defined in Section 298.5 of the California Family Code, or dependent child (including a stepchild or

adopted child) who is under age 19 or who is a full-time student under age 25, of (1) an eligible employee who dies while receiving or entitled to receive disability benefits under section 5.38.020; or (2) a Covered Employee who dies after five years of continuous service with the County or as a direct consequence and result of injury or disease arising out of and in the course of the performance of his or her assigned duties; provided, however, that to be an LTD Health Survivor, an individual must be a spouse, domestic partner or dependent child who is covered by a County-sponsored medical plan offered under a Cafeteria Plan at the time of: (i) the onset of a total disability as determined by the Claims Administrator, or (ii) if the Covered Employee dies before he makes a claim for disability under the LTD Plan, the date of death.

J. "Medical Dependent" means a Covered Employee's spouse, domestic partner or dependent child who is eligible to be covered under the terms of a County-sponsored medical plan.

K. "Qualifying period" means that a qualifying period shall be required with respect to any one period of disability and shall be a continuous period equal to the six months, commencing with the first day on which an eligible employee is absent from work due to a total disability, and during which he or she remains totally disabled except as provided below; however, this period shall not include any time prior to the operative date of the ordinance codified in this chapter. If the eligible employee ceases to be totally disabled and returns to work for less than an aggregate of 30 days during a qualifying period, any such cessation of total disability shall not interrupt continuity or

extend the duration of the qualifying period used to determine the first day on which benefits commence, provided that the successive absences during the qualifying period are due to the same cause. In addition, the continuity of the qualifying period shall not be interrupted, nor shall the qualifying period be extended, merely because an eligible employee incurs a disability during such period that arises from a different and unrelated cause than that which initially caused the eligible employee to be absent from work as long as the eligible employee does not return to active employment at any time during the six months commencing with the first day on which the eligible employee was first absent from work due to a total disability.

L. "Retirement plan A, B, C, or D" means any of the contributory retirement plans established by the county of Los Angeles pursuant to the County Employees Retirement Law of 1937.

M. "Retirement Plan E" means the optional noncontributory retirement plan made operative for general members of the Los Angeles County Employees Retirement Association on or after July 1, 1981, by resolution of the board of supervisors of Los Angeles County pursuant to the Memorandum of Understanding entered into in 1981, by and between the county of Los Angeles and the County Coalition of Unions.

N. "Total disability". During the qualifying period, and during the subsequent 24-month period for which an employee might be eligible to receive benefits under this Plan, "total disability" means the complete and continuous inability and incapacity of the employee to perform the duties of his or her position with the county. After the

expiration of 24 consecutive months of eligibility for benefit payments, total disability means that the employee is disabled within the meaning of the Federal Social Security Act and is eligible to receive or is receiving disability benefits under the Federal Social Security Act; provided, however, that for an employee who makes timely application for disability benefits under the Federal Social Security Act and who has not received a final determination regarding disability under that Act, total disability (for the period prior to the date on which a final determination is made regarding disability) shall mean the complete and continuous inability and incapacity of the employee to perform the duties of his or her position with the county. An employee who is not insured for disability benefits (such as lacking sufficient quarters of covered employment) under the Federal Social Security Act shall be considered totally disabled at the end of the 24-month period of eligibility for benefit payments and during the continuance thereafter of the disability if he or she is disabled within the meaning of Section 223(d) of the Federal Social Security Act.

SECTION 18. Section 5.38.020 is hereby amended to read as follows:

5.38.020 Disability benefits.

...

H. LTD Health Insurance.

~~1. An employee that is eligible for the Choices Plan or Local 660 Cafeteria Program may elect a disability health insurance benefit hereinafter referred to as "LTD Health Insurance." LTD Health Insurance shall provide health insurance~~

~~coverage on a concurrent basis with the payment of disability benefits under this Section 5.38.020. For each employee who elects this option, LTD Health Insurance shall provide employee health coverage to which the employee would otherwise be entitled if not disabled pursuant to the rules set forth in the applicable Choices Materials as defined in subsection N of Section 5.33.020 or the Local 660 Cafeteria Program Materials as defined in subsection P of Section 5.37.020.~~

~~2. The cost of LTD Health Insurance shall be borne entirely by the employees who elect this benefit through the Choices Plan or the Local 660 Cafeteria Program. Such cost shall be paid in the form of monthly employee contributions determined by the County to be the amount necessary to subsidize 75 percent of the cost of the health insurance actually provided under this provision. The remaining 25 percent shall be paid for by monthly employee payments at the time the coverage is received.~~

~~3. Any employee otherwise eligible to make benefit elections under the Choices Plan or the Local 660 Cafeteria Program may elect the LTD Health Insurance set forth in this subsection H; provided, however, that any employee who makes such election while either receiving benefits under this Plan or completing the Qualifying Period shall not be entitled to actually receive LTD Health Insurance unless and until the employee returns to work. Beginning on January 1, 2005, LTD Health Insurance will be extended to the survivor of an employee who is participating in the LTD Health Insurance Protection Program. A "survivor," for this purpose, shall mean a spouse, domestic partner as defined in Section 298.5 of the California Family Code, or~~

~~dependent child as defined in the Election Information; provided, however, that no person shall receive LTD Health Insurance survivor benefits under this provision if he or she was not an eligible survivor as of the onset of disability as determined by the Claims Administrator or date of death where death occurs with no preceding claim for disability benefits by the Eligible Employee or Participant under the LTD Plan.~~

~~4. LTD Health Insurance shall first be available under the Choices Plan and Local 660 Cafeteria Program beginning January 1, 2002. The provisions of this Section 5.38.020 H shall first be reflected on County pay warrants issued on or about January 15, 2002.~~

~~5. For new disabilities beginning on or after January 1, 2008, the LTD Health Insurance Benefits under the Local 660 Cafeteria Program set forth in paragraph (2) above shall be applicable on a nonelective basis for all Participants otherwise eligible for LTD benefits. In addition, Eligible Employees and Participants may elect a 100 percent LTD Health Insurance benefit which shall provide a subsidy toward the payment of the health insurance coverage to which the Participant would otherwise be entitled as an active employee equal to 100 percent of the total premium cost at the time the coverage is provided. The Eligible Employees and Participants electing this subsidy shall pay nothing toward the premium cost at the time the health insurance is actually received. Other rules regarding LTD Health Insurance benefit eligibility shall include the following:~~

~~a. For the 2008 Plan Year and for each Plan Year thereafter, any Eligible Employee or Participant who does not elect the optional 100 percent LTD~~

~~Health Insurance benefit shall be ineligible to make such election for the following Plan Year. The Eligible Employee or Participant must wait two Plan Years before again being eligible to elect this option.~~

~~b. In the event a Participant retires and becomes eligible to receive retiree health insurance from LACERA, LTD Health Insurance benefits will cease.~~

~~c. An Eligible Employee or Participant who elects to buy the 100 percent LTD Health Insurance benefit while receiving LTD benefits or while in the Waiting Period shall be limited to the 75 percent nonelective LTD Health Insurance benefit and shall not be eligible to receive the 100 percent elective LTD Health Insurance benefit with respect to that same disability until the employee returns to active employment for six months or more.~~

~~d. Such other benefit eligibility rules as may be determined necessary by the Chief Administrative Officer and set forth in the Election Information for the prudent administration of the LTD Health Insurance program.~~

1. Benefits for Covered Employee.

a. For disabilities incurred prior to (1) January 1, 2007, for Covered Employees eligible to participate in the Flexible Benefit Plan under subdivision 1 of Chapters 5.27 and 5.28 of this Code, or (2) January 1, 2008, for Covered Employees eligible to participate under either the Local 660 Cafeteria Plan or the Choices Plan: if the Covered Employee timely elects and pays for the 75 percent LTD Health Insurance Benefit in accordance with the terms of the applicable Cafeteria Plan,

the Covered Employee is covered by an LTD Health Insurance Benefit that pays for 75 percent of the cost of Applicable Health Insurance Coverage for the employee and his Medical Dependents during the period described in section 5.38.020H.3. The Covered Employee must make monthly contributions to purchase the 75 percent LTD Health Insurance Benefit, in amounts determined by the County, in accordance with the terms of the applicable Cafeteria Plan. The remaining 25 percent of the cost of Applicable Health Insurance Coverage elected by the employee shall be paid for by monthly employee payments in the time and manner determined by the County when the medical insurance coverage is received. Applicable Health Insurance Coverage will not be provided unless the employee timely remits his or her share of the cost for such coverage.

b. For disabilities incurred on or after (1) January 1, 2007, for Covered Employees eligible to participate in the Flexible Benefit Plan under subdivision 1 of Chapters 5.27 and 5.28 of this Code, or (2) January 1, 2008, for Covered Employees eligible to participate under either the Local 660 Cafeteria Plan or the Choices Plan: unless the Covered Employee makes the election provided in section 5.38.020H.1.c., he is automatically covered, at no cost, by an LTD Health Insurance Benefit that pays for 75 percent of the cost of Applicable Health Insurance Coverage for the employee and his Medical Dependents during the period described in section 5.38.020H.3. The remaining 25 percent of the cost of any Applicable Health Insurance Coverage elected by the employee shall be paid for by monthly employee payments in

the time and manner determined by the County when the medical insurance coverage is received. Applicable Health Insurance Coverage will not be provided unless the employee timely remits his or her share of the cost for such coverage.

c. For periods beginning on or after (a) January 1, 2007, for Covered Employees eligible to participate in the Flexible Benefit Plan under subdivision 1 of Chapters 5.27 and 5.28 of this Code, or (b) January 1, 2008, for Covered Employees eligible to participate under either the Local 660 Cafeteria Plan or the Choices Plan: if the Covered Employee timely elects and pays for the 100 percent LTD Health Insurance Benefit in accordance with the terms of the applicable Cafeteria Plan, the Covered Employee is covered by an LTD Health Insurance Benefit that will pay for 100 percent of the cost of Applicable Health Insurance Coverage for the employee and his Medical Dependents during the period described in section 5.38.020H.3. The Covered Employee must make monthly contributions to purchase the 100 percent LTD Health Insurance Benefit, in amounts determined by the County, in accordance with the terms of the applicable Cafeteria Plan.

2. Benefits for LTD Health Survivors

a. Each LTD Health Survivor with respect to a Covered Employee described in section 5.38.020H.1.a. or b. shall receive an LTD Health Insurance Benefit that pays for 75 percent of the cost of Applicable Health Insurance Coverage for that LTD Health Survivor during the period described in section 5.38.020H.3. The remaining 25 percent of the cost of any Applicable Health Insurance

Coverage provided to the LTD Health Survivor shall be paid for by monthly payments by that individual in the time and manner determined by the County when the medical insurance coverage is received. Applicable Health Insurance Coverage will not be provided unless the covered individual timely remits his or her share of the cost for such coverage.

b. Each LTD Health Survivor with respect to a Covered Employee who elects and purchases the 100 percent LTD Health Insurance Benefit as described in section 5.38.020H.1.c. shall receive an LTD Health Insurance Benefit that pays for 100 percent of the cost of Applicable Health Insurance Coverage for that LTD Health Survivor during the period described in section 5.38.020H.3.

3. Duration of LTD Health Insurance Benefit. The LTD Health Insurance Benefit shall be provided: (a) in the case of benefits provided under Section 5.38.020H.1., during the period that total disability benefits are paid under Section 5.38.020; and (b) in the case of benefits provided under Section 5.38.020H.2., until the LTD Health Survivor's death or until the individual no longer qualifies as an LTD Health Survivor; provided, however, that, in the event an individual receiving LTD Health Insurance Benefits becomes eligible to receive any retiree health insurance coverage from the Los Angeles County Employees Retirement Association (whether or not he or she elects to receive that insurance coverage), that individual's LTD Health Insurance Benefits will cease.

4. Limitations. Notwithstanding any other provision governing the LTD Health Insurance Benefit:

a. To be eligible to receive an LTD Health Insurance Benefit, a Covered Employee, Medical Dependent or LTD Health Survivor must be covered under a County-sponsored medical plan offered through the Cafeteria Plan at the time the LTD Health Insurance Benefit commences; provided, however, that an employee receiving an LTD Health Insurance Benefit may elect to cover a Medical Dependent during open enrollment in accordance with Cafeteria Plan rules or to the extent otherwise required by applicable law.

b. Any eligible employee receiving disability benefits under this Chapter 5.38 or completing the qualifying period: (1) shall not be entitled to become covered by (if not already covered), or elect to increase the level of, the LTD Health Insurance Benefit unless and until the employee returns to work as a Covered Employee, and (2) will not be entitled to become covered by (if not already covered), or elect to increase the level of, the LTD Health Insurance Benefit with regard to that same disability unless and until the employee returns to active employment as a Covered Employee for at least 6 months. Additionally, any Covered Employee who does not elect the optional 100 percent LTD Health Insurance Benefit shall be ineligible to make such election for the following Plan Year. The Covered Employee must wait two Plan Years before again being eligible to elect this option.

5. Subject to the County's obligation to meet and confer with employee organizations, other benefit eligibility rules or procedures may be determined necessary by the Chief Executive Officer for the prudent administration of the LTD Health Insurance Benefit program and set forth in the applicable Cafeteria Plan documents and materials.

SECTION 19. Section 5.39.030 is hereby amended to read as follows:

5.39.030 Supplemental life insurance.

The county will pay a premium of $500.00 per month during the lifetime of each eligible officer or employee for life insurance and/or another suitable funding vehicle approved by the Chief Administrative Officer to fund benefits for said officers or employees, under such terms and conditions determined by the Chief Administrative Officer to be consistent with the requirements of this section. To the extent that any benefits are available, such life insurance or other funding vehicles shall provide for a full refund of all county paid premiums by no later than the later of separation from service, death or ineligibility on the part of any officer or employee for benefits under this section. All remaining benefits shall accrue to the officer or employee or his or her beneficiary. All officers or employees whose status is one of the following are eligible to receive this benefit:

A. Persons designated as department heads pursuant to subsection A, D, H, J, K, or L of Section 2.02.190 of this code or county officers described in Article II, Section 4 or Article IV, Section 12 of the County Charter; and

B. Persons employed as Chief Deputy Chief Executive Officer (UC) or Deputy, Chief Executive Officer (UC); and

~~B.~~C. The employee compensated pursuant to Section 6.127.020 A of this code; and

~~C.~~D. Other officers or employees designated by the board.

SECTION 20. Chapter 5.41 is hereby added to read as follows:

Chapter 5.41

Options Dependent Care Reimbursement Plan

SECTIONS:

5.41.010 Purpose.

5.41.020 Definitions.

5.41.030 Participation and coverage.

5.41.040 Contributions and funding.

5.41.050 Dependent care expense reimbursement benefit.

5.41.060 Procedures.

5.41.070 Plan administration.

5.41.080 Plan amendment or termination.

5.41.090 Miscellaneous provisions.

5.41.010 Purpose.

The Options Dependent Care Reimbursement Plan (the "Plan") was originally generally effective as of July 1, 1992 and formerly known as the Local 660 Dependent Care Spending Account. This amendment and restatement of the Plan is effective as of January 1, 2008, unless otherwise provided herein.

The Plan is designed to reimburse Qualifying Dependent Care Expenses of Covered Employees and is intended to qualify as a dependent care assistance plan under Code Section 129. Employee contributions to the Plan are made through The Local 660 Cafeteria Plan, set forth in Chapter 5.37 of the Los Angeles County Code, the provisions of which are incorporated by reference into this Plan to the extent applicable. County contributions may be made as provided under the terms of this Plan.

5.41.020 Definitions.

A. "Annual Contribution Credits" means the total amount of Employer Contributions and Employee Contributions credited to a Covered Employee's Dependent Care Account for a Plan Year.

B. "Annual Enrollment" means the period before the start of each Plan Year during which Eligible Employees may elect to participate in the Cafeteria Plan and the programs offered thereunder, including this Plan, for that Plan Year.

C. "Board" means the Board of Supervisors of the County.

D. "Cafeteria" Plan means The Local 660 Cafeteria Plan established under Chapter 5.37 of the Los Angeles County Code.

E. "Claims Administrator means" the person or entity, if any, to whom the Plan Administrator delegates claims administration, including responsibility for:

1. receiving and reviewing claims for Plan benefits,

2. determining benefit amounts payable,

3. disbursing benefit payments,

4. reviewing denied claims, and

5. determining appeals, under the terms and conditions of a written agreement with the Plan Administrator.

F. "Code" means the Internal Revenue Code of 1986; as amended.

G. "County" means the County of Los Angeles.

H. "Coverage Period" means the period within each Plan Year during which a Covered Employee is covered for any incurred Qualifying Dependent Care Expenses. The Coverage Period for each Plan Year begins: (1) in the case of an Employee who becomes an Eligible Employee and enrolls pursuant to Section 5.41.030A.1 prior to Annual Enrollment, on the first day of the month following the date the Employee completes the enrollment process, and (2) following enrollment during an Annual Enrollment pursuant to Section 5.41.030A.2, the first day of the next following Plan Year, and continues for the remainder of the Plan Year; provided, however, that a

Coverage Period does not include any period after which coverage has terminated or during which coverage is suspended in accordance with 5.41.030.

I. "Covered Employee" means an Eligible Employee who satisfies the enrollment, participation and coverage requirements of 5.41.030.

J. "Dependent Care Account" means the record-keeping account established by the Plan Administrator pursuant to Section 5.41.060B for each Eligible Employee who elects coverage under this Plan.

K. "Dependent Care Center" means a facility which provides care for more than six individuals (other than individuals who reside at the facility) and receives a fee, payment, or grant for providing services to any of the individuals.

L. "Earned Income" means wages, salaries, tips, other compensation, and net earnings from self-employment (as defined and limited by Code Section 32(c)(2)), but does not include amounts paid or incurred by an Employer for dependent care assistance to a Covered Employee. A spouse of a Covered Employee shall, for each month that spouse is a Full-Time Student or Incapable of Self-Care, be deemed to be gainfully employed and to have Earned Income of not less than $250 per month if the Covered Employee has one Qualifying Dependent and $500 per month if the Covered Employee has two or more Qualifying Dependents.

M. "Effective Date" of this Plan as amended and restated is January 1, 2008.

N. "Eligible Employee" means an Employee who is an eligible employee under the terms of the Cafeteria Plan and who works at least 8 hours or receives 8 hours of leave benefits in the prior calendar month.

O. "Employee" means any person who has been determined by an Employer (regardless of any determination made by any other person or entity) to be currently an employee of the Employer for federal income and/or employment tax purposes. The term Employee does not include any individual who has been classified by the Employer as an independent contractor or leased employee, except to the extent leased employees within the meaning of Code Section 414(n) must be taken into account in applying nondiscrimination testing required under the Code. In the event that the Internal Revenue Service, another governmental agency with the authority to make a reclassification, or a court of competent jurisdiction, issues a final, binding decision that one or more individuals should be reclassified as employees for federal income and/or employment tax purposes, the Employer may change the status of such individuals to Employees, effective as of a date determined by the Employer following such decision.

P. "Employee Contribution" means a contribution made to the Plan in accordance with Section 5.41.040A.1.

Q. "Employer" means the County and (1) any governmental entity of which the Board is the governing body, (2) the Los Angeles County Superior Court to the extent participation is otherwise authorized by state law or rules of court, and (3) any

related Employer which has adopted this Plan as a Participating Employer as described in Section 5.41.90.

R. "Employer Contribution" means a contribution made to the Plan in accordance with Section 5.41.040A.2.

S. "Full-Time Student" means an individual who during each of five calendar months of the Plan Year is a full-time student at an educational organization.

T. "Incapable of Self-Care" means that, due to physical or mental problems, an individual is incapable of caring for his hygienic or nutritional needs, or requires full-time attention of another person for his own safety or the safety of others.

U. "Maximum Annual Benefit" means, with respect to any Plan Year, the lesser of

1. $4,800 ($2,500 for a married individual filing a separate federal income tax return),

2. the Covered Employee's Earned Income for the Plan Year, or

3. if the Covered Employee is married at the end of the Plan Year, the Earned Income of the Covered Employee's spouse for the Plan Year.

V. "Non-Represented Employees' Plan" means the County of Los Angeles Non-Represented Employees' Dependent Care Reimbursement Plan.

W. "Participating Employer" means an Employer which adopts this Plan in accordance with Section 5.41.90.

X. "Plan" means this Options Dependent Care Reimbursement Plan, as amended from time to time.

Y. "Plan Administrator" means the person, entity, or committee appointed according to Section 5.41.070A, who is responsible for managing the Plan's operation and administration. If a Plan Administrator is not appointed, the County shall serve as Plan Administrator.

Z. "Plan Year" means the 12-month period beginning January 1 and ending December 31.

AA. "Qualifying Dependent" means any of the following who has the same principal place of abode as the Covered Employee for more than half of the calendar year:

1. a qualifying child (as defined in Code Section 152(c)) of the Covered Employee who is under the age of 13, and

2. a spouse or other dependent (as defined in Code Section 152, determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B)) of the Covered Employee who is Incapable of Self-Care. Notwithstanding the foregoing, if Code Section 152(e) applies to a child who is under age 13 or is Incapable of Self-Care, he shall be treated as a Qualifying Dependent of the Covered Employee if the Covered Employee is the custodial parent (as defined in Code Section 152(e)(4)(A)).

BB. "Qualifying Dependent Care Expenses" has the meaning set forth in Section 5.41.050.

CC. "Status Change" means:

1. a change in legal marital status, including marriage, death of spouse, divorce, legal separation, or annulment;

2. a change in the number of dependents, including birth, adoption, placement for adoption, or death of a dependent;

3. a change in the employment status of the Eligible Employee or the Eligible Employee's spouse, including an increase or decrease in the number of hours of employment by the Eligible Employee, a change in worksite, a strike or lockout, or commencement or return from an unpaid leave of absence;

4. a dependent satisfying or ceasing to satisfy the requirements for being a Qualifying Dependent, unless the dependent's ceasing to satisfy such requirements is due solely to attainment of age 13; and

5. any other event the Plan Administrator determines permits revocation of an election under Code Section 125 and the regulations, rulings or other guidance issued thereunder.

5.41.030 Participation and coverage.

A. Enrollment.

1. Initial Enrollment. An individual who first becomes an Eligible Employee after the Effective Date but prior to an Annual Enrollment initially may participate in the Plan by completing the Cafeteria Plan enrollment process within the 60-day period beginning on the date the Employee becomes an Eligible Employee. Coverage for an Eligible Employee who enrolls in accordance with this Section shall be effective on the first day of the calendar month next following the date he completes the Cafeteria Plan enrollment process; provided, however, that an Eligible Employee who completes enrollment during November will not participate until the start of the next Plan Year. Except as provided in section 5.41.030A.3, if an Eligible Employee fails to enroll, he or she will not participate in the Plan for the remainder of the Plan Year.

2. Annual Enrollment. Prior to the beginning of each Plan Year, the Plan Administrator will conduct an Annual Enrollment, during which Eligible Employees may make new elections or change existing elections effective for the next following Plan Year. An Eligible Employee may become or continue to be a Covered Employee under this Plan by completing the Annual Enrollment process by the end of the Annual Enrollment period established by the Plan Administrator. Coverage elected under this Plan during an Annual Enrollment shall be effective as of the first day of the Plan Year following the Annual Enrollment. If an Eligible Employee fails to enroll, he or she will not participate in the Plan for the next following Plan year.

3. Change in Employment Classification During Plan Year.

a. If a participant in the Choices Dependent Care Reimbursement Plan or the Non-Represented Employees' Plan for a Plan Year ceases to be eligible thereunder but becomes an Eligible Employee under this Plan during that Plan Year, he will have the opportunity to enroll in this Plan under Section 5.41.030A.1, provided, however, that his coverage under this Plan will not become effective until the first day of the second month following the date he completes the enrollment process. If he fails to complete the enrollment process within the 60-day period described in Section 5.41.030A.1, he will automatically become a Covered Employee under this Plan effective as of the first day of the second month after the 60-day enrollment period ends, and his election regarding the level of his employee contributions under the Choices Dependent Care Reimbursement Plan or Non-Represented Employees' Plan will continue in effect under this Plan for the remainder of the Plan Year.

b. If a Covered Employee ceases to be a Covered Employee and becomes eligible to participate in the Choices Dependent Care Reimbursement Plan or Non-Represented Employees' Plan during a Plan Year, he will have a 60-day period in which to complete the enrollment process for that plan; provided, however that his coverage under the Choices Dependent Care Reimbursement Plan or Non-Represented Employees' Plan will not become effective until the first day of the second month following the date he completes the enrollment process. If he fails to complete the enrollment process within the 60-day period, he will automatically begin participating

in the Choices Dependent Care Reimbursement Plan or Non-Represented Employees' Plan, as applicable, effective as of the first day of the second month after the 60-day enrollment period, and his election regarding the level of Employee Contributions under this Plan will continue in effect under the Choices Dependent Care Reimbursement Plan or Non-Represented Employees' Plan, as applicable, for the remainder of the Plan Year.

4. Enrollment Information and Deadlines. In order to complete the enrollment process during initial enrollment or Annual Enrollment as described in this Section 5.41.030, an Eligible Employee shall specify the amount of Employee Contributions, if any, to be credited to his Dependent Care Account and the corresponding Annual Contribution Credits for the Plan Year, and shall provide any other information required by the Plan Administrator. The form and content of any enrollment materials, and any limitations with respect to the time for completing the enrollment process, shall be determined by the Plan Administrator and communicated to Eligible Employees prior to enrollment.

5. Limits. The maximum Annual Contribution Credits that may be elected under the Plan for any Plan Year is the Maximum Annual Benefit as defined in Section 5.41.020U. The amount that may be excluded from the gross income of a Covered Employee and his spouse, if any, with regard to Qualifying Dependent Care Expenses reimbursed under this Plan or any other dependent care reimbursement plan in any calendar year shall be limited in accordance with Code Section 129.

B. Coverage.

1. Initial Coverage. An Eligible Employee may become a Covered Employee during a Plan Year as of the first day of the calendar month next following the date he completes the Cafeteria Plan enrollment process in accordance with Section 5.41.030A.1. Except as otherwise provided in this Section 5.41.030, coverage shall remain effective for the balance of the Plan Year.

2. Annual Enrollment. Prior to the beginning of each Plan Year, the Plan Administrator will conduct an Annual Enrollment, during which Eligible Employees may make new elections or change existing elections effective as of the first day of the next following Plan Year. Except as otherwise provided in this Section 5.41.030, benefit elections shall remain effective for the entire Plan Year.

3. Change in Employment Classification During Plan Year. An Eligible Employee who enrolls or is defaulted into coverage in accordance with Section 5.41.030A.3.a shall become a Covered Employee as of the first day of the second calendar month after either (a) the date he completes enrollment or, (b) if he is defaulted into the Plan, the end of the 60-day enrollment period. Except as otherwise provided in this Section 5.41.030, coverage shall remain effective for the balance of the Plan Year.

4. Coverage During Leave of Absence or When Not Receiving Pay. A Covered Employee's coverage under the Plan shall continue while he is on a paid or unpaid leave of absence even if no Employer Contributions or Employee Contributions

are credited to his Dependent Care Account during that period; provided, however, that the Covered Employee's Annual Contribution Credits will be reduced to reflect any Employee Contributions and Employer Contributions that are not made during that period.

C. Termination of Coverage.

1. Date Coverage Ceases. Plan coverage ceases upon the earliest to occur of:

a. the first day of the second month immediately following the date the Covered Employee ceases to be an Employee or an Eligible Employee, unless the Covered Employee has changed employment classification and plan participation during the Plan Year as described in Section 5.41.030A.3.b;

b. in the case of a Covered Employee who changes employment classification and plan participation during the Plan Year as described in Section 5.41.030A.3.b., the first day of the second month following the earlier of (1) the date he completes the enrollment process under the Options Dependent Care Reimbursement Plan or Non-Represented Employees' Plan, or (2) the end of the 60-day enrollment period;

c. the effective date of the Covered Employee's election not to participate, or failure to elect to participate, in the Plan under Section 5.41.030A.1 or 2;

d. the effective date of any Plan amendment that terminates coverage for the Covered Employee's job category; or

e. the date of Plan termination.

2. Effect of Termination of Coverage. No benefits are payable for Qualifying Dependent Care Expenses incurred after Plan coverage terminates (and before the date, if any, that it is reinstated).

D. Revoking and Changing Elections.

1. General Rule. Except in extraordinary circumstances described in this subsection D, benefit elections shall be irrevocable for the Plan Year for which they are made. Any new benefit election made under this subsection D must be made within 90 days beginning on the date of the event that is the reason for the new election. Any new benefit election shall be effective on the first day of the month following the correct and timely completion and submission of all required forms. This subsection D shall be interpreted and applied in accordance with applicable Treasury regulations and in a nondiscriminatory manner in accordance with Code Sections 125 and 129.

2. Revocation of Elections for Status Change; Consistency Rule.

a. General Rule. The Plan Administrator may, in its discretion, permit (i) a Covered Employee to revoke a benefit election under the Plan and make a new benefit election or (ii) an Eligible Employee who is not participating in the Plan to make a benefit election and commence participation in the Plan, if a Status Change

occurs and the election change or new election satisfies the consistency requirements described in subparagraph 2.b below.

b. Consistency Rules. An election change or new election satisfies the requirements of this paragraph if the election change or new election is on account of and corresponds with a Status Change that affects (i) eligibility for coverage under an employer's dependent care reimbursement account plan, or (ii) expenses described in Code Section 129.

3. Cost Changes.

a. Significant Cost Changes. If the cost of a Covered Employee's Qualifying Dependent Care Expenses significantly increases or significantly decreases during a Plan Year, or if the cost to the Covered Employee (e.g., the necessary level of Employee Contributions) to maintain the elected Annual Contribution Credits for the Plan Year increases due to the reduction or termination of Employer Contributions under Section 5.41.040A.2, the Plan Administrator, in its discretion, may permit any affected Covered Employee to revoke his existing election and make a new election to reflect the increased or decreased cost.

b. Limitation. Notwithstanding anything to the contrary in this Section 5.41.030D.3, no election changes under the Plan shall be permitted as a result of a change in cost for Qualifying Dependent Care Expenses imposed by a dependent care provider unless such change in cost is imposed by a dependent care provider who

is not a qualifying relative (as defined in Code Section 152(d)) of the Covered Employee.

4. Significant Improvement or Curtailment of Coverage (Services). If the dependent care services being provided to a Covered Employee are significantly improved or curtailed (e.g., if the entity or person providing dependent care services changes or if the hours of services provided change), the Plan Administrator, in its discretion, may permit the Covered Employee to revoke his existing election and make a new election to reflect the cost of the modified services.

5. Change in Coverage Under Another Employer Plan. The Plan Administrator may permit a Covered Employee to prospectively change or revoke an existing benefit election under the Plan if the election change is on account of and corresponds with a change made under another Employer plan (including a plan of the same Employer or of another Employer) that would be permitted under this Section (without regard to this subsection 5.). The Plan Administrator also may permit a Covered Employee to make a prospective election to drop coverage under the Plan if dropping such coverage is on account of and consistent with adding coverage under another Employer's plan provided that the period of coverage or plan year under the plan does not correspond with the period of coverage or Plan Year under this Plan.

5.41.040 Contributions and funding.

A. Contributions.

1. Employee Contributions. During enrollment in accordance with Section 5.41.030, and pursuant to the terms of the Cafeteria Plan, an Employee may elect to have his Employer credit a portion of his Contribution (as defined in the Cafeteria Plan) to his Dependent Care Account. The amount elected may not be less than $10 or more than the amount that, together with any monthly Employer Contribution, would cause his Annual Contribution Credits to exceed the Maximum Annual Benefit. To the extent permitted under Code Sections 125 and 129, Employee Contributions will be treated like non-taxable Employer contributions.

2. Employer Contributions. Each Employer may contribute up to a designated dollar amount per month to the Plan on behalf of each Covered Employee employed by that Employer who elects to receive an Employer Contribution. Subject to negotiation with the certified bargaining organizations that represent an Employer's Eligible Employees, the Employer shall establish the maximum amount of the monthly Employer Contribution that it will make on behalf of each Covered Employee, as well as any annual cap on total Employer Contributions, for each Plan Year. The Plan Administrator shall disclose to Eligible Employees prior to enrollment the maximum level of Employer Contribution that may be made on behalf of each Covered Employee and the existence of the cap. A Covered Employee does not need to make Employee

Contributions to receive an Employer Contribution. An Eligible Employee who does not enroll in the Plan will not be entitled to an Employer Contribution.

In the event an Employer establishes an annual cap on Employer Contributions on behalf of Covered Employees, the Employer may, without prior notice to Covered Employees and at any time during the Plan Year, reduce or terminate the Employer Contribution to be made for some or all Covered Employees in any manner consistent with Code Section 129(d) and the terms negotiated with the Eligible Employees' bargaining unit representative(s) to prevent the cap from being exceeded. The Plan Administrator shall notify affected Covered Employees if their Employer Contributions will be reduced or terminated and their Annual Contribution Credits reduced due to imposition of a cap.

3. Termination or Suspension of Contributions: An Employer will not make an Employer Contribution or Employee Contribution for a month on behalf of a Covered Employee if he works less than 8 hours or receives less than 8 hours of leave benefits in the prior month. An Employer also will not make an Employer Contribution or Employee Contribution on and after the first day of the second month after the Covered Employee ceases to be an Employee or an Eligible Employee unless the Covered Employee changes employment classifications and plan participation as described in Section 5.41.030A.3.a. If the Covered Employee changes employment classifications and plan participation as described in Section 5.41.030A.3.a, he will not

receive an Employer Contribution or Employee Contribution on or after the date his coverage under the Plan terminates in accordance with Section 5.41.030C.1.b.

B. Plan Funding. The Plan is not required to be and is not funded or insured. Benefits paid to a Covered Employee are paid solely out of the general assets of the Employee's Employer.

5.41.050 Dependent care expense reimbursement benefit.

A. Reimbursement of Qualifying Dependent Care. Subject to the terms and limits set forth in this Section 5.41.050, Covered Employees may be reimbursed for Qualifying Dependent Care Expenses as defined in Section 5.41.050B.

B. Qualifying Dependent Care Expenses Defined. Qualifying Dependent Care Expenses means expenses incurred by the Covered Employee for household services or for the care of a Qualifying Dependent but only if such expenses are incurred to enable the Covered Employee (and the Covered Employee's spouse, if any) to be gainfully employed or to search for gainful employment for any period for which there are one or more Qualifying Dependents with respect to the Covered Employee, and subject to the exclusions set forth in Section 5.41.050C. For these purposes:

1. A Covered Employee's spouse is deemed gainfully employed for each month that he is a Full-Time Student or is Incapable of Self-Care.

2. Volunteer work for a nominal salary does not constitute gainful employment.

3. Expenses paid for a period during only part of which a Covered Employee or spouse is gainfully employed or in active search of gainful employment must be allocated on a daily basis, unless such expenses are incurred during a short, temporary absence from work (such as for vacation or minor illness) and the dependent care arrangement requires payment for care during the absence. An absence of two consecutive calendar weeks is deemed a short, temporary absence.

4. Expenses are for the care of a Qualifying Dependent only if their primary purpose is to assure the individual's well-being and protection. Expenses incurred for the care of a Qualifying Dependent may include employment taxes on the wages of a care provider, the additional costs of room and board for a care provider over usual household expenditures, and expenses that relate to, but are not directly for, the care of a Qualifying Dependent such as application fees, agency fees and deposits if the Covered Employee is required to pay those expenses to obtain the related care. Forfeited deposits or other payments are not for the care of a Qualifying Dependent if care is not provided in connection with those amounts.

5. Expenses are paid for household services if they are paid for the performance in and about the Covered Employee's home of ordinary and usual services necessary to the maintenance of the household, provided the expenses are attributable to the care of a Qualifying Dependent. Services of a housekeeper are household services if the services are provided, at least in part, to the Qualifying Dependent.

6. Expenses that are incurred for services outside the Covered Employee's household may qualify as Qualifying Dependent Care Expenses only if such expenses are incurred for the care of a Qualifying Dependent described in subsection 5.41.020AA1 of this Plan or any other Qualifying Dependent who regularly spends at least 8 hours each day in the Covered Employee's household.

7. Expenses that are incurred for services provided outside the Covered Employee's household by a Dependent Care Center may qualify as Qualifying Dependent Care Expenses only if such center complies with all applicable state and local laws and regulations applicable to such facility.

8. The cost of transportation by a care provider of a Qualifying Dependent to or from a place where care of the Qualifying Dependent is provided may be for the care of the Qualifying Dependent.

9. Qualifying Dependent Care Expenses are incurred on the date the dependent care is provided, not on the date charged, billed, or paid.

C. Exclusions. Notwithstanding any other provision of this Plan to the contrary, Qualifying Dependent Care Expenses do NOT include:

1. Any amounts paid for services outside the Covered Employee's household at a camp where the Qualifying Dependent stays overnight.

2. Expenses incurred in connection with services rendered by: (a) a Covered Employee's child or a child of the Covered Employee's spouse who is under

the age of 19 as of the end of the Plan Year, or (b) a person who qualifies as a dependent of the Covered Employee or a dependent of the Covered Employee's spouse and for whom a deduction is allowable under Code Section 151(c) to the Covered Employee or to the Covered Employee's spouse for the Plan Year.

3. The costs of a Qualifying Dependent's food, clothing, entertainment, or education (unless for a child below kindergarten) unless those costs are incidental, minimal, and inseparable from the cost of caring for a Qualifying Dependent.

4. The costs of transportation other than as provided in subsection 5.41.050B.8.

D. Coverage Period Limitations. Qualifying Dependent Care Expenses reimbursed by the Plan for a Plan Year must have been incurred during the Coverage Period. Accordingly, with regard to each Plan Year, the Plan will not reimburse any expenses incurred:

1. before the start of the Plan Year or after the end of the Plan Year,

2. before a benefit election becomes effective in accordance with Section 5.41.030, or

3. after coverage terminates or during a period in which coverage is suspended in accordance with Section 5.41.030.

E. Amount Payable. Reimbursement of Qualifying Dependent Care Expenses may not exceed the Annual Contribution Credits elected for the Plan Year, or the balance credited to a Covered Employee's Dependent Care Account at the time such reimbursement is made. Any unused balance in a Covered Employee's Dependent Care Account after the claims period described in Section 5.41.060C has expired shall be forfeited.

F. Code Limitations on Benefits. Benefits payable under the Plan to each highly compensated Employee, as defined in Code Section 414(q), are limited to the extent necessary to avoid violating the nondiscrimination requirements contained in Code Section 129.

5.41.060 Procedures.

A. Enrollment and Election Procedures. Eligible Employees may enroll, specify the amount of his Employee Contributions and designate the corresponding Annual Contribution Credits for a Plan Year only by completing the enrollment procedure in accordance with Section 5.41.030. Upon initial eligibility and during Annual Enrollment, the Plan Administrator will provide all Eligible Employees with information about permissible benefit elections under the Plan and procedures for enrollment and benefit elections.

B. Dependent Care Accounts. The Plan Administrator shall establish a Dependent Care Account for each Covered Employee. Each Covered Employee's Dependent Care Account will be credited with Employee Contributions and/or Employer

Contributions in accordance with Section 5.41.040, and will be debited by the amount of any Qualifying Dependent Care Expenses paid or incurred on behalf of the Covered Employee under the Plan for the Plan Year. The amount of Qualifying Dependent Care Expenses payable from the Plan at any time shall be limited pursuant to Section 5.41.050E of the Plan. Any unused balance in a Covered Employee's Dependent Care Account after the claims period described in Section 5.41.060C has expired for any Plan Year shall be forfeited.

C. Claim Procedures. Any Covered Employee (or duly authorized representative) seeking Plan benefits shall assert a claim under the procedures of this Section regardless of the basis asserted for the claim or when the act or omission occurred on which the claim was based. The Plan Administrator or Claims Administrator will provide, upon request, forms required for filing a claim for Plan benefits and instructions on the information that must be submitted for the claim to be processed. The Plan Administrator shall determine the information that must be included in any claim submission. Such information may include, but is not limited to:

1. itemized bills or receipts,

2. the amount, date, and nature of the expense,

3. the name, address, social security number or tax identification number and signature of the provider,

4. the name of the person for whom the expense was incurred and the person's relationship to the Covered Employee,

5. the amount, if any, that has been reimbursed or is reimbursable from any other source, and

6. any other information required by the Plan Administrator.

Claimants must complete and file the appropriate forms with the Claims Administrator by June 30th following the close of the Plan Year to which the claim relates.

D. Claim Determination. The Plan Administrator or Claims Administrator shall determine all matters pertaining to claims for Plan benefits. If the Plan Administrator or Claims Administrator denies a Covered Employee's claim for benefits, the entity reviewing such claim shall notify the Covered Employee in writing of such denial within a reasonable period of time.

E. Claim Review Procedures.

1. Appeal Process. A Covered Employee may appeal an adverse benefit determination under the Plan to the Plan Administrator by filing an appeal to the Plan Administrator within 180 days of receiving notice of the adverse benefit determination. If the Plan Administrator upholds the adverse benefit determination on appeal, it shall provide written notification to the Covered Employee of such determination as soon as reasonably possible.

2. Determination Final. The Plan Administrator's decision on appeal shall be final and binding on all persons.

5.41.070 Plan administration.

A. Plan Administrator. The County of Los Angeles shall act as Plan Administrator except to the extent that it delegates its responsibilities in accordance with Section 5.41.070.

B. Plan Administrator's Duties. The Plan Administrator's duties include:

1. Management of Plan operations and administration according to the Plan's terms and for the exclusive benefit of Covered Employees;

2. Maintenance of:

a. records and data necessary or desirable for the Plan's proper operation and administration; and

b. governing documentation of the Plan for inspection by any Covered Employee under the Plan;

3. Notification of Eligible Employees of the Plan's availability and terms; and

4. Preparation and filing of all annual reports or returns, Plan descriptions, financial statements, and other documents required by law or under the Plan's terms.

C. Plan Administrator's Powers. The Plan Administrator may exercise, in a uniform and nondiscriminatory manner, sole and absolute discretion in the Plan's operation and administration, including:

1. Establishment of such rules and regulations not inconsistent with the terms of the Plan as it deems necessary or proper for the efficient administration of the Plan and for the payment of benefits under the Plan;

2. Interpretation of the Plan, making decisions regarding all questions of the eligibility of persons to participate in the Plan and making factual determinations under the Plan, construction of any ambiguous provision of the Plan, correction of any defect, supplying any omission, or reconciliation of any inconsistency, in such manner and to such extent as the Plan Administrator in its discretion may determine, and any such action of the Plan Administrator will be binding and conclusive upon all Covered Employees;

3. Appointment of such agents, counsel, accountants, consultants, and other persons as may be required to assist in administering the Plan, including, without limitation, Employees of an Employer or a third-party Claims Administrator; and

4. Allocation and delegation of responsibilities under the Plan and designation of such departments, Employees, committees, entities, or persons including, without limitation, a third-party administrator (such as a third-party Claims Administrator), to carry out any of its responsibilities under the Plan.

D. Plan Administrator Determinations and Actions. The Plan Administrator shall use ordinary care and diligence in performing its duties.

1. Expenses and Compensation. Unless the County agrees otherwise, the Plan Administrator shall serve without compensation. The County shall pay all reasonable expenses the Plan Administrator incurs in performing its duties.

2. Indemnification. The County shall indemnify and hold harmless any Employee who serves or served as Plan Administrator from all claims, liability, and costs (including reasonable attorneys' fees) arising out of being the Plan Administrator or performing the Plan Administrator's duties, except if the claim, liability, or cost is the result of such individual's willful misconduct or bad faith.

5.41.080 Plan amendment or termination.

A. Permanence of the Plan. The Plan shall continue in full force and effect unless amended or terminated by the County as provided in Section 5.41.080B hereto.

B. Plan Amendment or Termination. The County reserves the right to amend or terminate the Plan at any time; provided, however, that the termination of the Plan or the amendment of any provisions subject to negotiation under applicable law shall be negotiated with the affected certified bargaining organizations.

C. Effect of Amendment or Termination; No Vested Rights. No amendment or termination of the Plan shall have any retroactive effect so as to deprive any Covered Employee of any benefit then payable. Notwithstanding the foregoing, any amendment or termination of the Plan may be made retroactive to the extent necessary for the Plan to comply with any applicable law. No Covered Employee has any vested right to continue to receive benefits under the Plan.

5.41.090 Miscellaneous provisions.

A. No Employment Rights. Nothing contained in the Plan shall be construed as a contract of employment between an Employer and any Employee, or as the right of any Employee to continue in the employment of an Employer, to be employed for any specific period of time.

B. Exclusive Obligations and Rights. The County, an Employer, and the Plan Administrator do not have any obligation or duty other than as stated in the Plan and, except as specified in this document, no one has a right to Plan benefits or a legal or equitable right against the County, the Board, an Employer, the Plan, or the Plan Administrator.

C. No Assignment of Benefits. Except to the extent required in accordance with applicable law, Plan benefits are not subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, levy or charge of any kind, and any attempt to effect any of these actions is void.

D. Misrepresentation or Fraud. A Covered Employee who receives a Plan benefit as a result of false or incomplete information or a misleading or fraudulent representation shall repay all amounts the Plan paid and is liable for all collection costs including attorneys' fees and court costs.

E. Legal Action.

1. Exhaustion of Administrative Procedures. Before pursuing legal action, a person claiming Plan benefits or seeking redress related to the Plan shall first exhaust all claim, review and appeal procedures provided by the Plan. No action at law or in equity may be brought to recover Plan benefits or seek redress related to the Plan until the claim procedures contained in Section 5.41.060 have been exhausted.

2. Necessary Parties. Unless otherwise required by law, the County and the Plan Administrator are the only necessary parties to any action or proceeding that involves the Plan or its administration. No Employee, Employer or other person or entity is entitled to notice of any legal action, unless a court with appropriate jurisdiction orders otherwise.

F. Governing Law. The Plan's provisions and all Plan matters, including actions of the parties involved, are construed and enforced according to applicable California laws unless preempted by federal law.

G. Governing Instrument. This writing, together with any documentation incorporated by reference, is the legal instrument governing the Plan. In case of conflict between this document and any of the writings incorporated by reference, the provisions of the documentation govern in the following order: this document, any other plan document, any summary plan description, any enrollment or election form, and, finally, any other writing; provided, however, that in the event of a conflict between this document and an applicable memorandum of understanding with a certified bargaining

organization representing Eligible Employees, the conflict shall be resolved in accordance with County Code section 6.28.140. Except as provided in this section 5.41.090G., no writing or evidence may contradict or interpret the Plan's terms or provisions unless specifically incorporated by reference herein.

H. Savings Clause. If a Plan provision or its application is held invalid under governing law by a court of appropriate jurisdiction, the remainder of the Plan and its application will not be affected.

I. Parties' Liability. Neither the County, the Board, an Employer, the Plan Administrator, nor any delegate thereof, shall be liable for:

1. good faith reliance on any fact or absence of fact, good faith action, or good faith omission,

2. another person's act or omission, unless required by law, or

3. the tax consequences of contributions to or benefits paid from the Plan.

J. Tax Consequences Not Guaranteed. Neither the County, the Board, an Employer, the Plan, the Plan Administrator, nor any other person connected with any such person or entity guarantees that Plan benefits are or will be excludable from a Covered Employee's gross income for federal, state, or local income tax purposes, or that any other tax treatment is or will be applicable or available. Covered Employees themselves shall determine whether Plan benefits are excludable for these purposes,

and shall notify the Plan Administrator if they have reason to believe a payment is not excludable. If the Plan Administrator determines at any time after the end of a Plan Year that contributions to the Plan or benefits paid exceeded limits allowed by law for any reason including, but not limited to, erroneous information, administrative error or failure to satisfy prohibitions on discrimination, then affected Covered Employees shall:

1. pay any local, state, and federal income taxes and related penalties and interest due with respect to the excess contributions or benefits, and

2. reimburse the Employer for the Employee's share of any local, state, and federal tax contributions the Employer would have withheld or other applicable deductions the Employer would have taken had the excess contributions or benefits been treated as taxable income.

K. Nondiscrimination. If, in the judgment of the Plan Administrator, the Plan may fail to meet the requirements of Section 129(d) of the Code, the Plan Administrator will take such action as it deems appropriate to assure compliance with such requirements. The action taken by the Plan Administrator may include, without limitation, a modification of the elections of certain Covered Employees who are defined as "highly compensated employees" under Code Section 414(q). Such action may be taken by the Plan Administrator without consent of the affected Covered Employee.

L. Participating Employers. With the County's consent, an Employer may adopt or withdraw from this Plan.

Each Participating Employer shall file with the Plan Administrator a notice of adoption specifying:

1. the effective date of its adoption, and

2. any other information the Plan Administrator may require to carry out its duties under the Plan. Except for functions reserved to the County, the Plan Administrator has exclusive authority over all Plan matters and acts as agent of all Employers that have at any time adopted the Plan.

An adopting Employer may withdraw from Plan participation by giving the County and the Plan Administrator 60 days advance written notice of its withdrawal. Similarly, the County may terminate an Employer's Plan participation by giving the Employer and Plan Administrator 60 days advance written notice of the termination. Upon an Employer's withdrawal or termination of participation, the Plan Administrator must provide the Employer with copies of all records that the Plan Administrator determines necessary for the Employer to terminate and administer its portion of the Plan. An Employer's withdrawal or termination of Plan participation operates only as to that Employer's Employees.

SECTION 21. Pursuant to Sections 25123(e) and 25123(f) of the Government Code, this ordinance shall take effect immediately upon final passage. If this ordinance becomes effective after January 1, 2007, it shall be construed and applied as if it were effective and operative on and after January 1, 2007, except Section 19 which shall be construed and applied as if it were effective and operative on April 26, 2007, and

Sections 1, 3, 5, 7, 9, 10, 12, 13, 15, and 20 which shall be operative on January 1, 2008.